RHODE ISLAND MEDICAL JOURNAL

JULY, 1954

The Administration's Health Program and the American Medical Association

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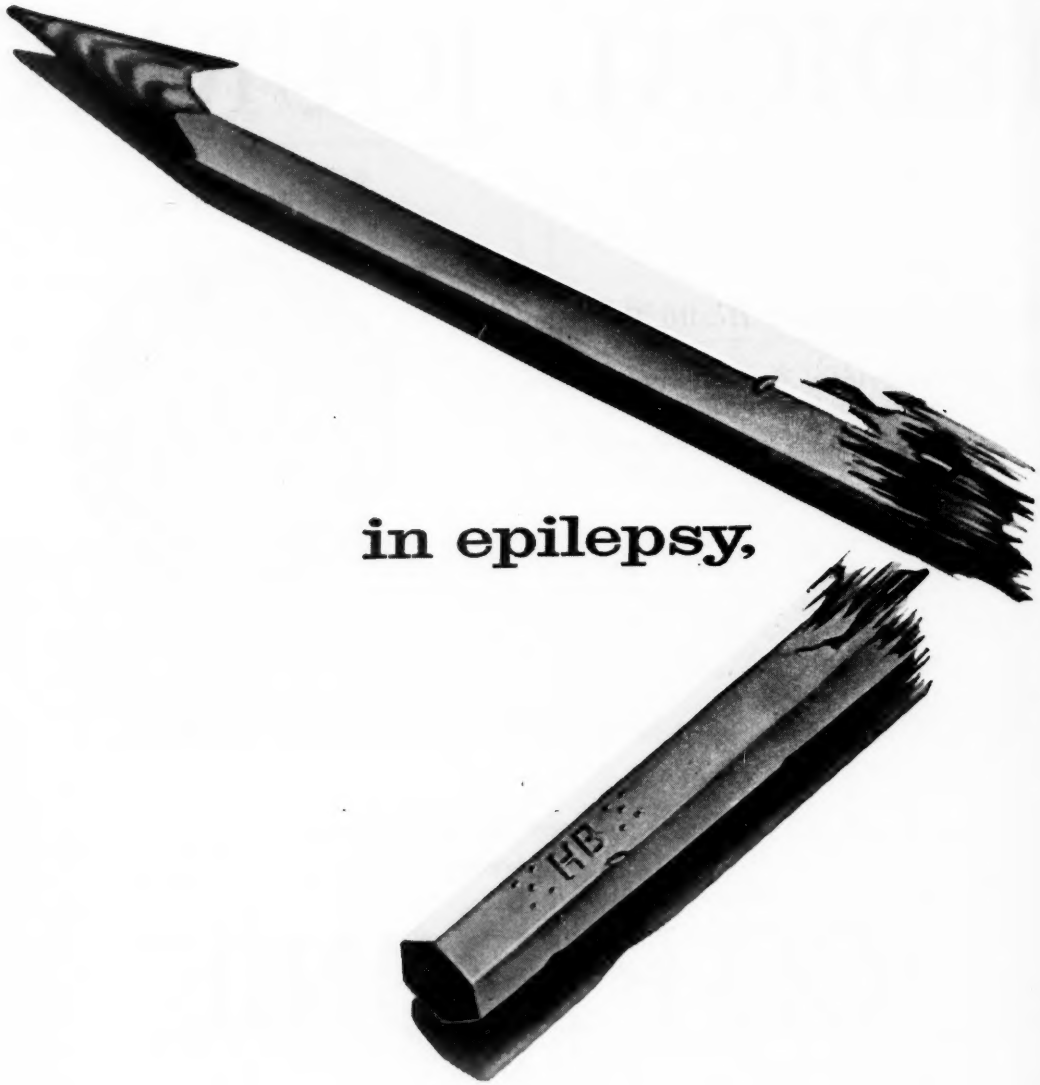

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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXXVII JULY, 1954 NO. 7

CORTISONE AND HYDROCORTISONE IN THE TREATMENT OF ALLERGIC DISEASES*

WALTER S. BURRAGE, M.D. AND JOHN W. IRWIN, M.D.
TECHNICAL ASSISTANTS: MARY GILCHRIST AND PRISCILLA GORDON

The Authors. *Walter S. Burrage, M.D., of Boston, Massachusetts, Associate Physician, Massachusetts General Hospital and Instructor in Medicine, Harvard Medical School; John W. Irwin, M.D., of Boston, Massachusetts, Research and Clinical Fellow in Medicine, Massachusetts General Hospital.*

Introduction

THE PURPOSE of this paper is to present a suggested outline for the indications and methods of administration of cortisone and hydrocortisone in the therapy of allergic diseases and related syndromes. Differences of opinion naturally exist as to when and how these hormones should be used. Such differences may not be resolved for several years to come as hydrocortisone, cortisone, and corticotropin have only been available for a relatively short period of time. Moreover, modes of action of these hormones as yet are not understood. Any suggested outline for indications and methods of administration must, therefore, be tentative. The use of corticotropin will not be considered here as this hormone offers no advantage over cortisone and hydrocortisone, and the side effects of corticotropin often appear more difficult to control.

Indications for Use

Cortisone and hydrocortisone have proved effective in relieving symptoms of allergic diseases, but no evidence to date proves that these hormones alter either antigens or antibodies. Symptoms tend to recur shortly after the effective hormone has been withdrawn. The physician, therefore, frequently finds himself in the position of having given his patient most welcome relief and of being reluctant to discontinue the hormone because of the likelihood of immediate return of symptoms. It must be emphasized, therefore, that cortisone and hydrocortisone should not be employed as a substitute for established procedures of allergic investigation and care or even to replace older medications selected for affording temporary relief unless such agents have repeatedly proved ineffective. These hormones do not act quickly like epinephrine. Their delayed effective action limits their use in immediate severe shock-like reactions, and they must be employed in any case before the patient is in extremis. The potential seriousness of some of the side effects of both hormones requires that the patient be informed that such effects may appear. He should also know the dose and the hormone which he is taking, and should volunteer this information to any physician in attendance at an accident or prospective operation. He should realize that increase, reduction, or discontinuation of the hormone without supervision may well lead to serious difficulty. He should report promptly any deviation from the normal to his physician. Table 1 summarizes a few general observations which may be of assistance in avoiding some of these dilemmas.

Table 1

1. Do not employ Cortisone and Hydrocortisone as a substitute for established investigative procedures in allergy.
2. Never use these hormones if older routine measures promise success.
3. Always tell the patient that they only suppress symptoms.
4. Always inform the patient that these hormones may cause undesirable effects but that close supervision and cooperation can lessen the chances of their appearance.
5. If symptoms appear to threaten life and if Cortisone or Hydrocortisone therapy is to be given a trial, act promptly.
6. Do not depend upon these agents alone if other therapeutic measures can help and they usually can.

THESE HORMONES ARE NOT MIRACLE DRUGS.

Diseases customarily grouped under the heading of allergy and related syndromes have all been reported to have their symptoms suppressed at least temporarily by cortisone or hydrocortisone. See for instance: asthma,[1,2,3,4] serum disease,[5] drug allergy,[5,6] contact dermatitis,[7] urticaria,[8] Henoch-Schoenlein's Purpura,[9] atopic eczema,[10] hay fev-

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*From the Medical Service of the Massachusetts General Hospital and the Department of Medicine, Harvard University. Presented by Walter S. Burrage, M.D., at the 143d Annual Meeting of the Rhode Island Medical Society, at Providence, R. I., May 5, 1954.

er,[11] migraine,[12] erythroblastosis fetalis,[13,14] periarteritis nodosa,[15] and lupus erythematosus.[16]

Granting the ability of these hormones to abolish symptoms, the main emphasis must be placed upon the justification for their use. The decision to employ these potent agents should rest upon the severity of the disease, failure of symptoms to respond to other therapy and the experience of the physician with these hormones. Table 2 may assist in such evaluation.

Table 2

OFTEN JUSTIFIED	OCCASIONALLY JUSTIFIED	NOT JUSTIFIED
Asthma - intractable	Urticaria - Angioedema (severe)	Hay Fever
Status Asthmaticus	Henoch-Schoenlein's Purpura	Vasomotor Rhinitis
a. Non-allergic	Erythroblastosis Fetalis	Serum shock (severe)
b. Allergic	Infantile Eczema	Ménières
Drug Allergy (severe)		Migraine
Serum Allergy (severe)		Urticaria, mild
Contact Dermatitis (severe)		
Periarteritis Nodosa		
Lupus Erythematosus		

Some of the manifestations of allergy warrant hormonal therapy to a greater extent than do others. Severe intractable asthma presents one of the most justifiable indications for this type of treatment. A small group of these patients has asthma which has persisted around the clock for months and often for years with minimal relief from established forms of medication. Here the cause of the asthma is frequently undetermined and the patient has already entered upon chronic invalidism, unable to support himself or to fulfill a useful role in society. In such instances, patients can often be rendered symptom-free with adequate doses of these hormones and maintained without asthma for prolonged periods of time on optimal doses. In the majority of other instances in which cortisone or hydrocortisone are suitable, the duration of severe allergic manifestations may be expected to be of relatively brief duration. This is true in status asthmaticus of allergic (extrinsic) origin. If this dramatic situation does not respond promptly to routine antiasthmatic measures, hormonal therapy will usually bring the emergency under control and may then be discontinued in favor of more conservative treatment. For instance, the patient with pollen asthma of known etiology may get into serious trouble at the height of his pollen season with or without previous hyposensitization. The problem here is not only one of producing temporary symptomatic relief but of maintaining freedom until the end of the pollen season. Acute sensitivity reactions to drugs[5] and to sera may also be controlled by the hormones when other drugs have failed. Symptoms may then be suppressed until the allergic process has run its course. The span of an incapacitating poison ivy attack[7] and other forms of contact dermatitis may likewise be similarly shortened. Periarteritis nodosa[15] and lupus erythematosus,[16] represent two of the chronic diseases which are often included in the allergy basket and which respond well to these agents. The severity of these disorders, their customary downward course and the temporary relief afforded by cortisone and hydrocortisone amply justify their prolonged use in these diseases.

It is not so easy to justify the employment of the hormones for the control of allergic symptoms that are milder and more transient. Among the rarer disorders having an allergic component, Henoch-Schoenlein's purpura[9] may respond satisfactorily to these hormones, and even erythroblastosis fetalis[13,14] may warrant an attempt at prevention or relief. Patients with infantile or atopic eczema usually do not require cortisone or hydrocortisone therapy. There is, however, a small group whose symptoms are very severe and persistent and who do not respond to routine therapy. In such cases,[17] hormonal therapy is justified. These agents will often control symptoms of pollen hay fever but such therapy is not recommended, as routine hyposensitization, supplemented by antihistamine therapy, has proved satisfactory. Perennial vasomotor rhinitis can usually be handled adequately by a combination of anti-allergic measures and otolaryngological procedures. The rare, severe, anaphylactic type reaction to drugs such as penicillin or to sera often runs its course too rapidly for hormonal therapy to be effective. These agents have little justification in the treatment of Ménières syndrome, migraine or mild urticaria.

Contraindications

Before a final decision is made to prescribe either cortisone or hydrocortisone, certain contraindications must be considered. Table 3 may prove

Table 3
CONTRAINDICATIONS

ABSOLUTE	POSSIBLE
Active tuberculosis	Arrested tuberculosis
Gastro-intestinal bleeding	Existing acute infection
a. Peptic ulcers	History of peptic ulcer
b. Ulcerative colitis	Diabetes, uncomplicated
Diabetes complicated by	History of psychosis
vascular change	Osteoporosis
Psychosis	
Thromboembolic phenomena	

a useful guide, but again the choice must rest with the physician. If the patient has active tuberculosis, gastro-intestinal bleeding from a peptic ulcer or from ulcers of the colon, these hormones should not be started. The same reasoning is applicable to patients with diabetes complicated by severe vascular changes, to patients in a psychotic state, or to patients with active thromboembolic disease. In such patients, the problem is usually easy to solve. In cases of arrested tuberculosis, healed peptic ulcer, uncomplicated diabetes, mild osteoporosis or mild infections, the decision is more difficult. It is always possible that a patient's asthma might be so persistent and intractable that an old scar at the right apex could be accepted as a calculated risk in using cortisone or hydrocortisone. It is very seldom, however, that it is justifiable to run the chance of activating tuberculosis or of precipitating gastro-intestinal hemorrhage in an effort to control allergic disease.

How to Use Cortisone or Hydrocortisone

From the antecedent discussion, it is evident that most of the patients who are to be placed on these hormones will be hospitalized. The exception is the ambulatory one with whom the physician is well acquainted medically, such as a case with severe contact dermatitis due to poison ivy. If it can be ascertained that there is no evidence of contra-indications and that the course of therapy will be relatively short, the physician may be justified in using one of these agents at home or on an out-patient basis.

Once the patient is in the hospital, certain basic studies are well worth while before starting hormone therapy, particularly if prolonged maintenance is under consideration. Such studies should include a complete history and physical examination, recording of weight and height, roentgenograms of the chest, thoracic and lumbar vertebrae and lateral skull, two twenty-four hour urine specimens for calcium, circulating eosinophiles and a fasting blood sugar.

After the patient has been placed on a moderately low sodium diet of about 1200 calories, he is ready for hormonal therapy. The initial aim is complete suppression of symptoms. Such suppression may be brought about in adults by 75 mg. of either cortisone or hydrocortisone every six hours for twenty-four hours, followed by 50 mg. every six hours until symptoms disappear. This usually takes about five days. In infants and children, 100 to 150 mg. per square meter every twenty-four hours should be sufficient.

Cortisone is available either in oral or intramuscular form whereas hydrocortisone may be procured in tablet form or as a solution for intravenous use. The route of administration depends upon the condition of the patient at the time the hormone is prescribed. If the problem is urgent, intravenous hydrocortisone (200 mg. in 1000 ml. of 5% glucose in water given as an intravenous drip over eight hours), may be effective.

Once symptoms are controlled, the next problem is to determine the length of maintenance therapy. In general, this period can be short. An example is the patient with uncontrolled swollen joints, albuminuria, angioedema and urticaria due to penicillin. Here clearing may usually be effected by 300 mg. of either oral hormone for twenty-four hours followed by 200 mg. daily for two or three days. The dose may then be lowered 25 mg. every twenty-four hours until the patient is off the hormone. If symptoms recur while the dose is being lowered or after it has been discontinued, the daily dose should again be increased to an effective level for a week or more. Then once again, step-like reduction is indicated. Even the most stubborn cases usually respond within a month. The patient with severe intractable asthma of undetermined etiology may have to remain on these hormones indefinitely. Here the problem is much more complex. Many points are illustrated in the following case report.

*E.H.—White, married woman—age 58 years. At age 54, in 1950, asthma first appeared after an upper respiratory tract infection. Her symptoms never cleared but progressively increased in severity; the course was downhill. Complete allergic studies failed to uncover any responsible antigens. The family history was free from allergic disease. In June, 1953, her physician tried small doses of cortisone (25 to 100 mg.) daily with little effect. Such a schedule was followed until September, 1953, when it was discontinued for lack of success. On January 5, 1954, she was admitted to the Massachusetts General Hospital with severe asthma.

Weight—86.5 pounds. Height—63.5 inches. She was a thin, white lady, propped up in bed, looking older than stated age. She was wheezing audibly. An emphysematous chest showed an increased anterior-posterior diameter and limited movement of the diaphragm. Slight tenderness was noted in the area of the right kidney.

She did not respond well to epinephrine, aminophylline, and potassium iodide. An intravenous solution consisting of 1500 ml. of 5% glucose, 0.5 Gram aminophylline, and 1 ml. of epinephrine 1-1000, given by slow drip, proved ineffective. Hydrocortisone therapy was considered.

Routine studies including scratch and intradermal skin tests were negative. In addition, roentgenograms were reported as follows: chest—emphysema; thoracic and lumbar vertebrae—mild osteoporosis; lateral skull—no osteoporosis. Bio-

*The hydrocortisone as well as the funds for this study were supplied by the Upjohn Company.

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chemical studies included: serum sodium—138 meq./liter; serum chloride—96 meq./liter; serum calcium—9.5 meq./liter; serum potassium—5.5 meq./liter; alkaline phosphatase—5.5 units; carbon dioxide—35 meq./liter; total protein—6.1 grams; fasting glucose—94 mg./100 cc; non-protein nitrogen—21 mg.%; urine calcium—95 to 130 mg./24 hours.

On January 11, 1954, she was given 50 mg. oral hydrocortisone every six hours. Her asthma completely cleared after six days and a total of 1.1 grams of hydrocortisone. During this time she developed right flank pain. An intravenous pyelogram showed a stricture at the junction of the pelvis and the ureter of the right kidney. Surgery was decided upon; and the stricture was removed January 20, 1954. Since the cortices of her adrenal glands might have been suppressed by hydrocortisone therapy and in view of anticipation of possible "stress" during surgery, she was given 50 mg. oral hydrocortisone every six hours the day before operation. On the day of surgery she received 200 mg. cortisone intramuscularly. For three days postoperatively this dose was continued. Then she was given 160 mg. oral hydrocortisone daily. Her course was uneventful. The dose was gradually reduced. On February 4, she returned home on 40 mg. of hydrocortisone daily by mouth, and she did well there in spite of the emotional strain to which she was subjected when her son was killed in an accident on February 20. On March 14, the hydrocortisone was lowered to 30 mg. Mild asthma gradually appeared. A week later she developed an acute respiratory infection and herpes zoster. On April 7, she was admitted to the hospital in status asthmaticus. She was then given 200 mg. hydrocortisone in 1000 ml. of 5% glucose by intravenous drip over eight hours during which time she improved markedly. For the succeeding forty-eight hours she received 50 mg. every six hours. On this, her asthma cleared. On April 9 she returned home on 150 mg. daily. Four days later this dose was reduced to 100 mg., and after another four days the dose was again lowered to 80 mg. on which she has remained. On May 1 she weighed 110 pounds, a gain of 23.5 pounds since onset of hydrocortisone; she felt well and was completely free from asthma.

Complications

Cortisone and hydrocortisone ordinarily give rise to only minor complications if they are used on a short-term basis and if the listed contraindications are taken into consideration. Patients who are maintained on these hormones over long periods of time usually develop certain characteristics of Cushing's syndrome. Several of these complications may become serious. For this reason, and to be certain that the patient is being maintained upon an optimal dose for suppressing symptoms, every patient must be watched closely. Some possible complications are listed in Table 4.

Almost all patients gain weight. This is due to a marked increase in appetite which in part is due to cortisone and in part to the relief of symptoms which formerly suppressed desire to eat. A low caloric diet, therefore, best suited to the individuals' need, must be followed. Since edema can appear, the diet should be moderately low in sodium. Acne occurs in a few patients, particularly in the male. Most women grow some facial hair. Decreased carbohydrate tolerance and potassium deficiency have not proved to be factors in a series of twenty-

Table 4

POSSIBLE COMPLICATIONS

MILD	SEVERE
1. Obesity	1. Osteoporosis
2. Acne	2. Vascular disease
3. Hirsutism	3. Psychosis
4. Edema	4. Growth arrest
5. Decreased carbohydrate tolerance	5. Edema
6. Potassium deficiency	6. Hypertension
7. Hypertension	7. Gastro-intestinal bleeding
8. Redistribution of fat	8. Acceleration of infection
a. "Moon" face	9. Interference in protein metabolism
b. Thin extremities	
c. Obese abdomen	
9. Facial rubor	

two severe intractable asthmatics, followed on maintenance cortisone or hydrocortisone for periods of one to three years. None of these patients have had supplementary potassium therapy. Most patients on long maintenance hormone treatment develop a characteristic Santa Claus appearance due to a redistribution of fat. This consists of a "moon face," obese abdomen, thin extremities, and facial rubor.

Osteoporosis must be considered as one of the more important serious complications. A common finding in Cushing's syndrome, it may lead to spontaneous fractures of the vertebrae or ribs. One such case has occurred in the group previously mentioned. Periodic studies, including twenty-four hour urine calcium excretion and roentgenograms of thoracic and lumbar vertebrae, may assist in anticipating this condition before such fractures occur. Vascular disease and hypertension have not been a problem in this group, but severe gastro-

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THE ADMINISTRATION'S HEALTH PROGRAM AND THE AMERICAN MEDICAL ASSOCIATION*

FRANK E. WILSON, M.D.

The Author. *Frank E. Wilson, M.D., of Washington, D. C., Director of the Washington Office of the American Medical Association.*

TWENTY YEARS AGO it was hardly likely that a paid lobbyist for the medical profession would have been invited to speak at your annual meeting here in Providence. In fact, there were no medical lobbyists, at least in Washington. It was unheard of for a member of the profession to be so close to politics as to be stationed in Washington on a full-time basis to report the shenanigans going on there, and to inform Congress of the opinions of physicians. What brought this about was the beginning of a social revolution which is still going on—and it will probably go on for some time. During revolutionary times there are many forces at work and many groups demanding to be heard. Perhaps it is Darwin's theory again being proved that the fittest survive. Washington, D. C., became the maelstrom of the collective forces and those groups demanding to be heard. Some voluntarily, some through necessity. It was to protect the interests of physicians, and their patients, and to exercise a rightful leadership, that the American Medical Association ten years ago established a Washington office. At first it was a listening post but now it is an action station as well.

You physicians were probably taught in medical school, as I was, that medicine and politics don't mix. They still don't mix if you mean partisan politics. But we live in a political world and we cannot escape it. Nor should we shun politics. It is the most vital part of democratic society. Politics is here to stay. As intelligent persons in a representative government, it is up to us, first as citizens and second as doctors of medicine, to participate in the making of laws and the election of law-makers.

As a representative of the AMA, I am not speaking tonight of those things that deal with putting a particular candidate in or out of Congress. You can do that as citizens of Rhode Island, but not as members acting on behalf of a medical organization. What you can do is to discuss with each candidate his views on the issues that are important to your practicing medicine the way you think it should be practiced. We want our success and our competence to be measured by our colleagues and our patients, and not by federal bureaucrats.

Just after the last national elections I selected Providence for a regional conference of New England states, to learn a little more about the men whom you had elected to Congress, and perhaps why in some cases, and to swap information with representatives of these state medical societies about the medical issues likely to come up in the 83d Congress. As in most of the other regional conferences, a doctor came up to me and said, "Wilson, your job will be easier now that Truman and Oscar Ewing are out of the way, won't it?" My stock reply was, that sometimes it is harder to work with your friends than with your enemies. One of the reasons I'm back in Providence tonight is to repeat, after a year and a half, that it is more difficult to work with your friends.

The AMA, in December 1952, formed a liaison committee of its top elected officials to work with and assist in every way the newly appointed department heads, the Congress, and the President himself. The committee met with Mrs. Hobby on February 4 last year and the next day was received by the President. We have seen Mr. Eisenhower on more than this one occasion, as you know. The committee spent weeks, not days, in Washington making overtures of cooperation and personally meeting all the leaders who have any direct influence on the medical profession, including Admiral Radford, Chairman of the Joint Chiefs of Staff. We saw him at the suggestion of the President, because Mr. Eisenhower thought we should get his views on medical care for the dependents of military personnel, and that he might benefit from ours.

It seemed to me that with 20 years of the closed-door policy, the new administration would hang a lantern in the window, and put a welcome mat at the front door for the doctors. I think it is accurate to say that Mr. Eisenhower has done this, but not all the high ranking officials have followed his lead. I hasten to add that I believe their reaction is without the knowledge, or permission of the chief. We called it the canvas curtain and it was lowered, we thought, by too many holdovers from the last re-

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*Presented at the Annual Dinner at the 143d Annual Meeting of the Rhode Island Medical Society, at Providence, R. I., May 6, 1954.

gime. This year things are a little bit different, but the curtain is never out of sight.

Medical Profession Ignored

The Secretary of the Department of Health, Education, and Welfare last year appointed a medical advisory committee, from physicians suggested by the AMA liaison committee. She has not once called this committee together, in spite of the fact that her own experts sat down and planned for the compulsory inclusion of physicians under Social Security. This step was taken with the Secretary's whole-hearted support. Whether you agree that you should be covered is not the point here. It is that the profession is being ignored. Not one single M.D. other than a government employee sat in on the several meetings that resulted in this decision.

The present administration had no positive health program its first year. 1953 was a year of adjustment and realignment, with the first half of the year spent under a Truman budget. During December of last year, Cabinet members and heads of independent agencies had formulated plans for their respective departments, then met together in a series of meetings, out of which came the present administration's policies and legislative program. This program was announced to the public in a series of special messages to the Congress in January of this year. The special health message was delivered January 18th. Bills have been introduced covering all major points and in addition, a few extra bills are under consideration supplementing the program.

It is now about half way through the second session of the 83d Congress and hearings have been held on practically all these bills, and a prognosis may be ventured on most of them.

The Reinsurance Proposal

All of you have heard that the major health program is reinsurance of voluntary health plans. This bill has an interesting background which is not generally known. In June of 1950, Congressman Wolverton of New Jersey, then a minority member of the House Interstate and Foreign Commerce Committee, introduced a bill proposing a federal corporation, similar to the one now in existence which reinsures banks against certain losses, for reinsuring voluntary non-profit health insurance plans. His bill, introduced late in the Congress and not important to the House leadership, received no committee consideration. I asked Mr. Wolverton at the time if the idea was his or somebody else's. This was one of my early blunders as a lobbyist—you never ask a Congressman if the idea he incorporates into a bill is somebody else's. He told me that he was fully capable of developing his own ideas. I learned later in the year that the idea came from Harold Stassen and that certain Blue Cross people had encouraged Mr. Wolverton. This was confirmed early this year by Mr. Wolverton in a conversation with me in his office.

What we are dealing with now, good and bad, is the Eisenhower administration's long-range health program. As I have indicated, most of it was not drawn up until last fall and early winter. It is not, I want to emphasize, it is not something that we have to be concerned with only for this session of Congress. The parts that are not passed now will be reintroduced in the next Congress. Even if there is a change in control of Congress after next fall's election, the Eisenhower administration will press for these bills, and there is no question that they would have the support of many, many democrats.

Obviously, the administration could not ignore the subject of health insurance. It would be expedient to come up with something appealing to a large segment of the population and yet different from compulsory health insurance. With Mr. Stassen high in the official family, and the word reinsurance sounding like free enterprise, it was adopted as the keystone of the administration's health program. Apparently no one seriously considered defining the word in terms of action, in terms of government, or in terms of political involvement, until it was mentioned by the President in his message on the state of the Union.

The whole AMA Board of Trustees had met in regular session in Washington in February and had hoped that the bill would have been introduced by that time. The Department of HEW had expected to have it ready, but on checking with the life insurance industry was amazed to find serious objections to the bill because it put government into the field of insurance in competition with private industry, and would not accomplish what it set out to do. By this time officials of the American Medical Association had had many discussions with all types of insurance people, bankers, industrialists, allied trade organizations, and professional groups. Many of these representatives appeared before a special meeting of the Board of Trustees held in Chicago for this very reason—all prior to the actual introduction of the bill. No position is ever taken on a bill until it is actually introduced, in spite of the fact that we are repeatedly asked to fall into a trap, by stating our position before we see the words and understand their meaning. As soon as the bill was introduced, the Committee on Legislation and the Executive Committee of the Board of Trustees met jointly in a special session, so that a position could be taken on this bill.

The only position that the AMA could take after so careful a study, was that we are in accord with the stated objectives, but must oppose the federal government's methods of reaching them as stated in the bill. In my opinion, the administration would

have to do some magical maneuvering to get the bill made into law this year.

The AMA's Position

Now, just about every time we oppose a major bill somebody always asks, "Why does the AMA always oppose everything? Why don't they come forward with an alternative?" The answer lies in the fact, that the AMA is one of the few national organizations which does not ask favors from Congress, and wants no federal money. A more succinct explanation was given to me the other day. I was told that nine of the ten commandments started out with, "Thou shall not. . . ." One of them says, "Thou shall not commit adultery," and the Bible does not suggest an alternative! Actually —although you don't see much of this in the press because it isn't sensational—actually the AMA supports almost every other bill of consequence in the Eisenhower health program. Not a part of the President's program, but strongly indorsed by the AMA, is the Jenkins-Keogh bill which would end tax discrimination against the self-employed, and allow them more adequately to provide pensions for themselves without dependence on Uncle Sam. That is our alternative to social security for physicians.

Another major bill proposes an extension of the Hill-Burton law, to include hospitals for the chronically ill, for nursing homes, rehabilitation and diagnostic or treatment centers. The AMA approves this bill in principle, and has offered some perfecting amendments, along with those of the American Hospital Association, which are being seriously considered by Congress and will probably be enacted into law. We are somewhat concerned that the definition of "diagnostic or treatment center" be spelled out more clearly, and regardless of the definition, that they be operated under the supervision of an accredited hospital. We expect that this will be the first health bill to be passed. It has already passed the House.

A new formula for giving public health grants to states, is another proposal which has the support of the AMA, generally speaking. This proposal eliminates categorical grants for specific diseases and leaves it up to the state authorities to say what public health program the money will be used for, with the exception of mental health. One section of the bill grants the Surgeon General too much liberty in a "unique projects" grant. He has the authority already, but this section is simply a gimmick to get more money out of the appropriations committee. We objected to this provision as being unnecessary, but feel that even *with* it the bill has merit.

The AMA has never taken a position *for* or *against* social security as such. It does object to the compulsory inclusion of physicians under this program. It does not object to the *voluntary* coverage of physicians, as is being proposed for educators and religious leaders. I am aware that in some quarters of the profession there is opposition to this position of AMA. My only answer to that is, that the majority rules. Another objectionable proposal, in the social security amendment bill, is a *waiver of premium* for permanent and total disability. We object to this on the grounds that it is not necessary, and that it would unnecessarily involve physicians by requiring them to make federal decisions on patients whose conditions may be considered permanent today, but tomorrow, with newer therapy, may be completely recovered. The federal government could exercise a remote control over doctors. On this point we have an alternative because we believe that persons who *are* in need of social security benefits due to disability, should be given consideration. This could be done by computing the 5 or 10 best years of a person's working record, and grant benefits on this basis. This method would be cheaper in administration, and could cover such other conditions as unemployment, and other justifiable and unfortunate situations. The Department of HEW is looking kindly toward dropping the 4 years of *least* earnings, and computing the benefits on the remainder. I am not an economist and do not understand the difference, unless the Department does not want labor to say the Department is the tool of the AMA.

Deductions from income tax for medical expenses is a small provision in the huge bill which proposes a revision of the income tax law. We have actively supported this idea for a number of years, and have encouraged some Congressmen to take the lead in sponsoring this legislation in separate bills. We have heard no one object to this proposal. The administration did not consider that this was part of a health program, and so I hereby gratuitously credit it to the Eisenhower health program anyway!

The latest health proposal came from the Defense Department. The bill proposing an extension of medical care for the dependents of military personnel has only recently been introduced in the Senate. There is no House bill yet. This bill follows the recommendations of the Moulton Commission report of last year. Essentially it suggests, that dependents of military personnel be given medical care and hospitalization whenever possible, in military hospitals. If medical care were not available, they would receive such care from civilian sources, with the federal government paying directly all beyond the first $10, but not more than 90% of the total bill.

The present situation as regards dependent care, is that the three services have no united, or equal, regulations on this subject. The army leaves it up

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to the commander of a hospital, as to the extent of beds and facilities he can make available, i.e., beyond those necessary for soldiers.

The AMA is not opposed to dependents getting medical care, if they are really dependent, and are the soldier's immediate family. Our thinking conflicts with military thinking in one or two areas. We believe that this bill would encourage the armed forces to bring dependents into military hospitals, resulting in a shortage of beds for the military personnel, and a shortage of medical officers to care for them. This situation always has a great appeal to Congress, because it involves the strength of the nation, and it is a rare Congressman who would vote nay to any such thing. This is not idle thinking. An example is the overgrown Veterans Administration hospital program, which started the same way. We don't want another "doctors draft" to take care of dependents, when there are ample facilities for them as for other citizens. We are in agreement with the Defense Department, that the military hospitals overseas and in isolated places should treat legitimate dependents. There is a need for unifying the regulations of the army, navy, and air force on this subject, but it is not necessary to extend the scope of this care. I might point out, that Congress has never legislated to grant military dependents medical care—it has been done by regulation, and not my statute.

In summary I think it would be safe to say that there has been a change in the federal government in its attitude towards health. The present administration is honest in its motives, but a little too desirous of pleasing everybody, including those who have been so *well* pleased for 20 years. The AMA has made every effort we know to be helpful, to steer the present leaders away from the socialization of medicine, and it has been and is, a rather difficult job to educate your friends on what is socialization. American medicine stands ready *always* to offer what assistance it can to the progress of medical science and art, and to the application of the finest medical care to more people, at the lowest cost. In order to defend the right of American physicians to organize themselves into a common purpose to bring about the finest medical care anywhere, the AMA had to be informed of those isms which were rampant in Washington at that time. We have won a partial victory. I am happy to say that the scope of the Washington office, and that of the entire medical profession has broadened. We want to be as helpful as possible to the federal government, so long as the rights guaranteed by the Constitution are kept intact, and the dignity of medicine is respected.

Your medical representatives in Washington are conscious of the fact that we represent *you* through the democratic system which the physicians of this country have set up. We must represent the collective thinking of medicine, and especially the state medical societies. Special groups within the medical organization should not use their strength to dissipate the unity of medicine in its basic framework.

You here in your official state society, are and should be the voice of physicians of Rhode Island, and that voice should be heard through the AMA to Washington. Then we could better represent you. But I want to leave you with this thought—you are the lobbyists for American medicine—and it is through your efforts that sound, helpful medical legislation can be enacted into law.

CO-2 THERAPY*

LAURENCE A. SENSEMAN, M.D., F.A.C.P.

The Author. *Laurence A. Senseman, M.D., F.A.C.P. of Sayleswille, Rhode Island. Physician-in-chief, Department of Neuropsychiatry, the Memorial Hospital, Pawtucket, Rhode Island.*

THE USE of Carbon Dioxide Therapy in the treatment of emotional disorders is one more neurophysiological treatment in the armamentarium of the psychiatrist which is gradually gaining more adherence with each passing year. In fact, a new organization, the Carbon Dioxide Research Association has recently been organized along the lines of The Electric Shock Research Association. Ever since Loevenhart,[1] in 1929, found that 30 to 40 per cent CO-2 with oxygen caused cerebral stimulation there has been interest in the use of CO-2 as a therapeutic agent.

In 1937 Kerr[2] again demonstrated its usefulness but it was not until 1948 when Meduna first began to treat psychoneurotic disorders, that this neurophysiological treatment became an accepted form of therapy. Meduna's CARBON DIOXIDE THERAPY,[3] published in 1950 by the Charles C Thomas publishers recommended the use of 30% CO-2 and 70% oxygen. These treatments were given three times a week in a series of 20 to 150 treatments. He purposely avoided any psychotherapy and still reported good results.

My first interest in this form of treatment was obtained in Montreal at the meeting of the American Psychiatric Association at which time I heard Meduna and others discuss the use of Carbon Dioxide Therapy (C.D.T.). Shortly after this, I purchased a standard anesthesia machine and with it, I began to use this form of treatment. First the patients were quite frightened and for two reasons: one, the mask had to be placed over the face and two, the CO-2 was rather irritating. Shortly after this, Meduna introduced a modification using Nitrous Oxide induction.[4] The patient is in light nitrous oxide anesthesia when a stream of CO-2 is turned into the machine and the patient given a 30% CO-2 and 70% oxygen mixture and after 8 to 15 deep breaths the patient was returned to nitrous oxide and thus a smooth induction was produced with little if any irritation to the patient.

*Presented at Psychiatric Staff Conference, C. V. Chapin Hospital, Providence, Rhode Island, March, 1954.

LaVerne[5] introduced the Rapid Coma Technique of inhalation therapy, 100% CO-2 with one deep breath; this avoided the pre-coma anxiety. I have not used this form of treatment. Wilcox[6] has used what he chooses to call, psychopenetration along with C.D.T. which is a form of psychotherapy and following certain leading questions that he has carefully outlined. Another worker, Jackman,[7] had his patients breathe until a convulsion was produced. These later two forms of treatment I have not tried either as the Meduna treatment has proven helpful in my patients.

The treatment itself is harmless and no fatalities have as yet been reported to my knowledge and there is no lasting unpleasant effect. The patients have, however, complained of suffocation and choking and after they awaken they state that they have dreams which are rather hard for them to recall, many cannot recall them at all. Some have a fear of impending death or disintegration and many have broken off the treatment because of a fear of it. The addition of nitrous oxide has greatly reduced this complication.

Indications for C.D.T. have been outlined on numerous occasions by many writers on the subject. In my own experience, the anxiety reaction, personality maladjustment with unconventional behavior and emotional instability, conversion symptoms or patients with organic disease who create physical symptoms, have been aided by C.D.T. Meduna includes, anxiety neurosis, alcoholism, dysphemia, overt homosexuality and other perversions, chronic inferior feelings, neurotic depressions, irritability intension symptoms, stuttering and psychosomatic disorders such as, asthma and skin allergy, duodenal ulcer, spastic colitis and ulcerative colitis. For many of these indications I have not yet used C.D.T.; my experience has been limited more to the psychosomatic, psychoneurotic and anxiety reactions. I have tried a large number of treatments on one severely handicapped man with stuttering but without any real relief. It is to be noted here that there is no help from C.D.T. on the psychotic patient. Obsessive compulsive patients and hypochondriacal patients do not benefit from this type of treatment.

Authors[8, 4, 5] of papers on this subject, who have contributed the most, suggest several contra-

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indications; previous coronary attacks, organic heart disease, advanced arteriosclerosis, malignant hypertension, pulmonary tuberculosis and emphysema. Until more is known about this treatment it would be wise to adhere to these contra-indications.

The treatment as used in my office is as follows: the patient is treated on a semi-rigid table without any preliminary preparation. After some reassurance he is given 90% nitrous oxide and 10% oxygen mixture. When the patient is about asleep, the nitrous oxide is turned off and carbon dioxide is turned on, the mixture being 30% CO-2 and 70% oxygen. The patient quickly begins to breathe deeply and involuntarily, he rapidly loses consciousness, there is some carpal pedal spasm, pupils are dilated, usually there is profuse sweating and salivation. After 8 to 15 deep breaths, the carbon dioxide is turned off and nitrous oxide is again used in terminating the treatment. During the course of the treatment, the patient may make noises, may even abreact and become very active physically but in no instance have I had any serious complications as far as the patient or myself are concerned. It is interesting to note that each patient usually follows a fairly definite pattern of reaction with each treatment. Some will come out laughing or smiling, others will become very frightened and frequently they will have the same type of frightening dream pattern. In a fear reaction, it is well to cut down on the number of inhalations of the carbon dioxide and the fear will usually disappear after a few treatments. If the patient is extremely tense after CO-2, it has been recommended that the treatment be repeated with fewer inhalations. I have tried this and have found it to work in several cases.

The next logical question is, how does this treatment help the patient? According to Lorente DeNo,[9] he states that there is a definite increase in membrane potential, an increase in the threshold of stimulation of the nerve cells and an increase in the ability of the nerve cells to release energy and there is also a decrease in the fatigability of the patient's nervous system. Gibbs and others, working with electroencephalography have found that there is a definite electrical activity change which is measurable with a slow 3-4 per second high voltage activity occurring about the 18th respiration. Meduna has suggested a reverberating circuit theory or feedback mechanism restoring homeostatsis. Wilcox has suggested that CO-2 is a specific agent for release of subconscious material.

A demonstration of the technique of C.D.T. was demonstrated on:

W.T., male, 18, high school graduate, preparing to enter college in the fall. He was seen in January of 1954 and he stated that he could not relax or enjoy himself. He had a minor difficulty with a girl friend and had been overly concerned about it. He was quite anxious, apprehensive and very much concerned about his future. He complained of a tremor of his hands and head. He is a very ambitious boy and wants to become a doctor and is planning to take the premedical course in college. He was having considerable difficulty in getting along with other people and couldn't enjoy himself in the presence of girls. He was anxious to have something done to relieve him from these feelings.

He was given 12 CO-2, N_2O treatments with marked improvement in his adjustment and attitude. It was interesting in his reaction to the treatment. Each time he would have a dream he would be doing something spectacular on a ball team and he would come out smiling and quite pleased with himself in spite of the fact he would be perspiring profusely. Treatment is being continued until improvement is certain and maintained.

A description of a typical case is as follows:

J.O'D., male, 22, gave a long history of maladjustment, since early adolescence. He is one of two siblings, his younger sister of whom he is very jealous is a well adjusted girl in college. This young man is the product of a very unhappy marriage; a poorly adjusted father who is a naval officer and alcoholic and a strong dominant mother to whom he is closely attached and toward whom he directs most of his hostility. During the course of his early adolescence, he was treated by a child guidance clinic; diagnosis, potential schizophrenic, and had been under the care of several psychiatrists before he came to my office. He was in an extremely anxious state, almost to the point of panic. He had many self-depreciating ideas, threatened suicide, ambivolent feelings toward his mother and much hostility toward his father. He was having serious difficulty in relating himself to men, especially his employer, as well as a girl friend who was living some distance away. He had been tested by a psychologist, was seen by a psychiatric social worker and had been in an excellent psychiatric clinic elsewhere. He is a high school graduate and wanted to enter college but felt that he could not go through with it.

Between October of 1952 and January of 1953, the patient received 48 CO-2, N_2O treatments as described. He took the treatments well in spite of the fact that he hated them. He was cooperative in every way. After this course of treatment, he was able to enter college in February of 1953 and he completed the school year satisfactorily. The summer of 1953 was spent working in Arizona. He re-entered college last fall. At the present time, he is doing very well.

This represents a rather severe anxiety with depression in a young man who had had previous psychiatric help. After a course of 48 treatments of CO-2, N_2O he was able to return to college and he has remained there ever since.

CONCLUSIONS

CO-2 is a safe form of office procedure, it is another form of neurophysiological treatment for nervous disorders which can greatly assist the psychiatrist in guiding his patient back to normalcy. While its actions are not entirely understood, its beneficial results cannot be completely disregarded by those who are genuinely interested in helping many patients who seek relief from their distressing symptoms.

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CORTISONE AND HYDROCORTISONE IN TREATMENT OF ALLERGIC DISEASES

concluded from page 374

intestinal bleeding of a duodenal ulcer has necessitated gastrectomy in one patient. The tendency for functioning tumors of adrenal cortex to arrest longitudinal growth in children should bring this possibility to mind when maintenance therapy is carried out in this age group. Infection can be masked by hormone therapy. In addition, infection unrecognized and untreated can spread rapidly in patients on maintenance therapy. All infections should be promptly reported and thoroughly investigated.

CONCLUSIONS

Cortisone and hydrocortisone are useful agents in controlling symptoms of allergic disease, but they should only be employed in carefully selected cases. Success with these hormones depends primarily upon careful supervision by the physician coupled with intelligent cooperation on the part of the patient.

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NEW WORKMEN'S COMPENSATION LAW

THE FIRST of this month the revised workmen's compensation law enacted by the General Assembly at its recent session will go into effect. The revision undoubtedly has some excellent features that will make for a better operation of this important program to assist the injured workman.

The Rhode Island Medical Society has sought for improvements in the legislation for years, and a year ago it even introduced its own ideas as to how the medical phases of the law should be redrafted. These ideas have been accepted in good part by the Assembly in enacting its final draft this past April.

Unfortunately all the interest publicly in the legislation was concentrated on the appointment of the three officers who will serve as the commission to operate the law henceforth. The political implications of the appointments were given far more press notice than were the aims of the legislation itself to improve the lot of the workman who is to benefit when he is injured. Now that the commission has been named, and its course charted to a good extent for it, we look forward to a better approach to the whole structure of workmen's compensation, especially since the long term appointments of the commissioners should eliminate the problem of partisan politics in the years ahead regarding this program.

Our interest, of course, is in the phases of the law relating to the medical and hospital care of the injured workman, and his speedy rehabilitation so that he may resume his work. We are pleased that some of our suggestions were incorporated in the provisions for impartial examinations, review of total disability cases, and special tests for back injuries.

A brief summary of the major changes in the medical care sections effective July 1 is as follows:

(1) The maximum allowance for services and medicines, exclusive of hospital services, is increased from $500 to $600 in the case of an employee hospitalized for more than 14 days.

(2) Any dispute regarding the reasonableness of the amount of any charge for services or medicine shall be determined by the commission after hearing, and its decision shall be final, if supported by a majority of the medical advisory committee.

(3) The physician's written notice that he is treating a workmen's compensation beneficiary is to be filed within 15 days, instead of 7 as now required, but in addition the new law stipulates that every two months

thereafter while the treatment continues a written progress report must be sent to the employer and a bill for services to date, and further, he must present his final bill for all unpaid services within three months after the conclusion of services.

(4) The impartial examiner no longer will have to send a copy of his report to the employee, as the employer or carrier must do that now upon receiving the medical report.

(5) The impartial examiner's report must be filed within 96 hours of the completion of each and every examination.

(6) The impartial examiner may be summoned for the purpose of cross examination by the commission.

(7) A medical advisory committee of seven physicians is to be appointed by the governor to serve without compensation for staggered terms to assist the department of labor and the commission. Three physicians will serve until March, 1955, two until March, 1956, and two until March, 1957, and thereafter appointments annually to fill the vacancies.

(8) Every case of total disability or severe permanent partial disability on which compensation has been paid for a year will be reviewed and such action taken by the director of labor or the commission, with the advice of the medical advisory committee, as shall seem practicable and likely to speed recovery.

(9) With the advice of the medical advisory committee the director of labor has the authority to prescribe a special report for back injuries, and to recommend specific tests to be performed in the diagnosis and treatment of such back injury, with the recommendation and approval of the employee's physician.

The inclusion of a medical advisory committee, serving without compensation, received little attention publicly. Yet this committee promises to be one of the most important factors in the revised program, for the aid it can and undoubtedly will give the new commission will do much for the successful operation of the law. At the same time, the committee should be in a position to develop medical criteria for the determination of causal relationship between injury, disease and disability that will be of great help to the physicians engaged in the practice of industrial medicine.

In spite of all the publicity given the legal implications and provisions of the new statute, the fact remains that the doctor is the indispensable man in workmen's compensation. The law cannot work without him and no award is made unless causal relation is established to an industrial accident or occupational disease. We know that the state labor department will continue to have the full cooperation of the society that it has had through the years, and we are certain that through the medical advisory committee the new commission will have a liaison with the entire medical profession that will benefit the injured worker of Rhode Island.

PETER AND PAUL

For some time our local industries have expressed concern about the increasing tax burden, both federal and state, as well as the increasing overall operating cost for doing business here in the northeast. We, as citizens, have in turn been equally disturbed by these problems, and by the transfer of many of our industries, particularly the textiles, to sunnier climes.

We have all been victims at one time or other of the blandishments of the warm weather enthusiasts who are most active when winter blankets our New England area. But we were sure that it was not relaxation in the sun that was enticing our industries south, and after noting the collection of income taxes by states, and the returns to the states of grants-in-aid we see one major reason why the south may indeed boast of a golden sunshine.

The federal internal revenue collections for the fiscal year 1953, as compared to the federal grants-in-aid and federal payments direct to individuals within the states, other than loans, provide us the following interesting data:

In 1953 Rhode Island paid in $298,684,677 and received back in grants and aids $18,892,333. The latter figure represents 6.32 of collections.

But the percentage returns of collections of our southern states who are competing with us for our industries, show a different pattern. Mississippi got back 50.31%, South Carolina 24.12%, Alabama 23.86%, Arkansas 44.78%, Louisiana 25.42%, and Georgia 17.39%.

In actual money this return represents a considerable amount of cash from the federal cornucopia. Consider Rhode Island and South Carolina.

We paid in $298 millions in taxes and got back less than $19 million in grants-in-aids.

South Carolina paid in $266 millions and won back a total of more than $64 millions in grants.

Thus the state that has three times our population from whom taxes are collected, paid in $32 millions of dollars *less* than us, and got back in grants-in-aid $45 millions *more.*

We believe strongly in the spirit of brotherly love and the united family, but robbing Peter to pay Paul has never made any family happy or united.

INSURANCE CLAIM FORMS

More than ten million accident and health claims are reported to be handled annually, representing payments in the aggregate of some three hundred millions of dollars. Most vexing problem for physicians in this problem is the variety of forms issued by the 600 or more insurance companies of the country involving the reporting of illnesses or accidents for which medical service is rendered and a claim thereby warranted.

In our March issue we published an outstanding article on the importance of uniform *processing* of insurance claims forms, and now we are happy to report further that the insurance industry is reportedly working towards a uniformity of forms to be used to obtain needed information from physicians and hospitals.

continued on next page

A special committee on Uniform Claim Forms, created by the Health Insurance Council, intensified the industry's efforts along these lines a year ago. To date five attending physicians' statement forms for use on claims under regular life and group life insurance have received broad company consideration and are now in final draft. Four of them are for disability—two initial and two continuing disability—and one for death claims. The fact that more than three-fourths of the companies of the United States and Canada engaging in this new study have agreed to use these forms, is a step in the direction of lessening the doctor's reporting work that will be welcome news to every physician, and especially those without secretarial assistance who often have to spend their "afternoon off" laboring over the answers to voluminous questionnaires on the health of their patients seeking insurance benefits.

O TO BE A TREE!

The Rhode Island General Assembly at its recent session expressed grave concern relative to the plight of the trees in our fair state by voting a tidy sum of $40,000, as a matching fund to help communities fight Dutch Elm disease, and in addition appropriated $10,000 for research on the disease at the University of Rhode Island.

The same Assembly turned down legislation designed to provide a much-needed improvement and expansion of public health service to the estimated 218,000 people living in Rhode Island's towns. This legislation resulted from a careful study by a special commission appointed by the governor. The measure left to the various towns the decision to participate or not in the program, and in anticipation that sufficient towns would embrace the idea the appropriation in the bill was set at $40,000.

The health of the trees was more important than the health of 218,000 people!

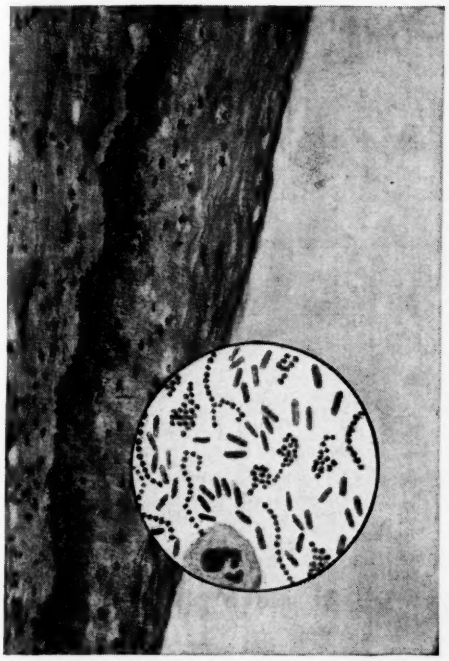
ANNUAL REGISTRATION

The task of maintaining an up-to-date register of physicians, even in a state as small as ours, presents a continuous problem for the state department of health and allied agencies in the health field. With the approval of the Rhode Island Medical Society a bill was introduced and enacted by the General Assembly that calls for an annual registration starting in October.

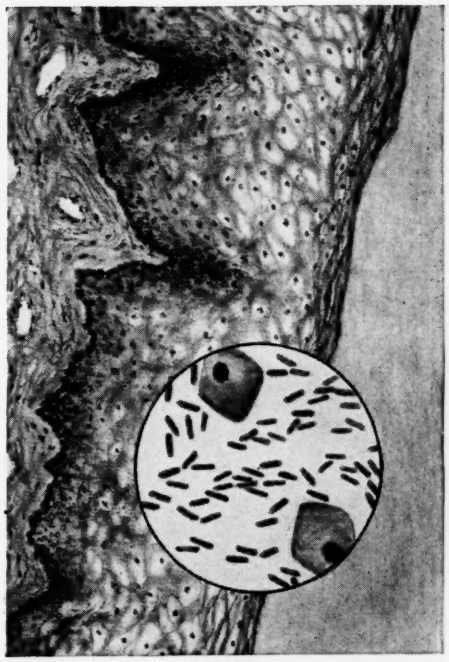
The registration fee is a dollar annually unless a physician fails to register within a thirty day period—October 1 to November 1 when the cost goes up to two dollars. Violation of the law calls for a $25 fine, but not revocation of license.

The new legislation involves no great hardship upon any physician, and certainly it will prove helpful in establishing an authentic list of licensed practitioners of medicine in this state. Any physician, inactive or retired from practice, may be excused from the registration fee by notifying the department of health in writing.

We call to the attention of our membership the complete bill as published in this issue and we urge every member to return his registration notice and fee promptly when notified by the state department of health early this fall.



Senile vaginal epithelium is low in glycogen, low in acid and (inset) low in protective Döderlein bacilli, encouraging growth of pathogenic organisms.



Normal vaginal epithelium is high in glycogen, is definitely acid and (inset) contains adequate Döderlein bacilli to combat pathogenic organisms.

Restoring the Normal Acid Barrier to Trichomonal Vaginal Infection

To discourage multiplication of trichomonads and to encourage physiologic protective mechanisms, a comprehensive therapeutic regimen with Floraquin® is instituted.

The normal vagina, by reason of its acid reaction, is provided with a natural barrier against pathogenic microorganisms which require an alkaline medium. When the "acid barrier" is removed, a hypo-acid state results and growth of the protective, physiologic and nonpathogenic Döderlein bacilli is inhibited—to be replaced by such pathogenic organisms as the trichomonad, streptococcus, staphylococcus, colon bacillus and Monilia candida.

As infection develops, the epithelial cell layers, which normally number between forty-five and fifty-five, may decrease to as few as fifteen to twelve layers or may disappear entirely. With this loss of glycogen-bearing cell layers, the available carbohydrate released by physiologic desquamation into the vaginal secretion and ultimately converted into lactic acid is proportionately decreased.

Floraquin not only provides an effective trichomonacide (*Diodoquin®*), destructive to pathogenic organisms, but furnishes sugar and boric acid for reestablishment of the normal vaginal acidity and regrowth of the normal protective flora. G. D. Searle & Co., Research in the Service of Medicine.

REVISED WORKMEN'S COMPENSATION LAW

Sections of the 1954 Workmen's Compensation Law Amendments enacted by the General Assembly

ARTICLE II PAYMENTS

"Sec. 5. Treatment and care of injured employees

"SEC. 5. *Treatment and care of injured employees.*

(a) The employer shall subject to the choice of the employee as provided in paragraph (b), promptly provide for an injured employee such reasonable medical, surgical, dental, optical or other attendance or treatment, nurse and hospital service, medicines, crutches and apparatus for such period as is necessary, in order to cure, rehabilitate, or relieve the employee from the effects of his injury, *provided, however,* that the charges for services and medicines exclusive of hospital services shall not exceed the sum of $300 in the case of an employee not receiving hospital services or receiving hospital services for not more than 14 days, and shall not exceed the sum of $600 in the case of an employee receiving hospital services for more than 14 days, and charges for diathermy and massage treatments in any case shall not exceed $75, and no fee for major surgery shall be paid, unless permission therefor in writing shall first be obtained from a member of the Workmen's Compensation Commission, the employer or the insurance carrier involved, except where compliance herewith may prove fatal to the employee. The charges for hospital services covering room, board and general nursing care shall not exceed $12 per day and the laboratory fees and the fees for x-rays and anesthetics shall be those customarily charged by the hospital. In case the amounts stipulated by this paragraph are not sufficient to cover necessary specialized or prolonged services, the Workmen's Compensation Commission may order payment of additional charges after hearing upon petition, and its decision shall be final. Any dispute as to the reasonableness of the amount of any charge for services or medicines shall be determined by the Workmen's Compensation Commission after hearing, and its decision shall be final, if supported by a majority of the medical advisory committee appointed under the provisions of Section 21 of this Article. The employer shall also provide all medical, optical, dental and surgical appliances and apparatus reasonably required to cure or relieve the employee from the effects of the injury, including, but not being limited to the following: ambulance and nursing service, eyeglasses, dentures, braces and supports, artificial limbs, crutches and other similar appliances.

In the case of his neglect or refusal seasonably to do so, the employer shall be liable for the reasonable expense incurred by or on behalf of the employee in providing treatment, and the refusal of the employee to accept treatment reasonably required to lessen or terminate his incapacity shall bar the employee from receiving compensation during the period of refusal.

(b) An injured employee shall at all times be entitled to treatment, care or rehabilitation by a physician, dentist or hospital of his own choice. Nothing herein contained shall prevent the treatment, care or rehabilitation of an employee by more than one physician, dentist or hospital.

No claim for care or treatment by a physician, dentist or hospital chosen by an employee shall be valid and enforceable, as against his employer, employer's insurer or employee, unless the physician, dentist or hospital gives written notice of the employee's choice to the employer within fifteen (15) days after the beginning of the services or treatment and shall as often as every two months thereafter, while the services or treatment continue, in writing present to the employer a signed progress report of the employee's condition, and a bill for services to date and shall, in writing, present to the employer a final bill for all unpaid services or treatment within three (3) months after the conclusion thereof.

(c) When an injury results in no incapacity or incapacity of less than three (3) days and the employer fails to authorize reasonable medical, dental and hospital services, the medicines necessary for the treatment of the injury, the director of labor may upon his own motion or he shall upon petition filed by the employee after hearing declare the employer liable therefor, whenever in his opinion the same are necessary for the proper treatment of the injury, and his decision shall be final.

(d) The term "dental services" as used in this section shall be construed to include services rendered in making, repairing and replacing artificial teeth and dentures. The term "hospital services" as used in this section shall be construed to include

any and all services normally furnished by the hospital for the care of patients.

(e) No hearing shall be held by the director of labor or by the Workmen's Compensation Commission or any member thereof under this section, unless written notice thereof shall be mailed to the employer and employee five days before the time of the hearing and decision shall be rendered within seventy-two (72) hours after the hearing, unless the parties shall otherwise agree.

"Sec. 21

"SEC. 21. The employee shall, after an injury, at reasonable times during the continuance of his disability, if so requested by his employer, submit himself to an examination by a physician, furnished and paid for by the employer. The employee shall have the right to have a physician, provided and paid for by himself, present at such examination. The employee shall be entitled to a full, exact, signed duplicate copy of the medical report of the examining physician, which shall be mailed by the employer or carrier to the employee or his attorney forthwith upon receipt of the original report by the employer or carrier. Failure to do so shall make such report or evidence of such examining physician inadmissible if objection is made by the employee to the admission of the report or evidence. Any member of the commission or the director of labor may, at any time after an injury, on his own motion or on the petition of the employer or employee, appoint a competent and impartial physician to act as a medical examiner, and the reasonable fee of such medical examiner, as fixed by the commissioner or director of labor, shall be paid by the employer.

Whenever, in any case arising under this chapter, any member of the commission or the director of labor shall have pursuant to the provisions of this section determined and fixed the reasonable fees of any impartial medical examiner, said medical fees shall be paid forthwith, and no appeal of any said case in which said impartial medical examiner shall have acted, taken to any court of this state shall act as a stay of any such order fixing the amount of said medical fees and ordering the payment of the same, unless the appeal is taken for the purpose of having the court determine the reasonableness of such charge made by the impartial medical examiner.

Such medical examiner, once being duly sworn by the director of labor or a member of the workmen's compensation commission appointing him to the faithful performance of his duties at the inception of his designation as an impartial medical examiner shall thereupon and as often as requested in accordance with this chapter, examine injured employees to determine the nature and probable duration of their injuries. Such medical examiner shall file a signed report within 96 hours of the completion of each and every examination made of such employees in the office of the clerk of the workmen's compensation commission or with the director of labor, as the case may be, in triplicate, and such report shall indicate the name and the title of the official by whom he was sworn in and appointed and shall then be acceptable as proper legal evidence in any hearing or proceedings before the workmen's compensation commission to determine the amount of compensation due such employee under the provisions of this chapter, and the examiner may be summoned for the purpose of cross examination. Copies of such reports shall be furnished to all interested parties. If any employee refuses to submit himself for any examination provided for in this chapter, or in any way obstructs any such examination, his rights to compensation shall be suspended and his compensation during such period of suspension may be forfeited.

The reasonable costs of transportation to and from the office of any impartial examiner appointed as hereinbefore provided, shall be charged to the employer and, if paid for by the employee, he shall be reimbursed in full for such expenditure by his employer, upon presentation of a receipt or other evidence of expenditure.

It shall be the policy of the department of labor and of the Workmen's Compensation Commission to speed the rehabilitation and return to remunerative employment of all disabled persons.

There shall be a medical advisory committee consisting of 7 physicians who shall be appointed by the Governor as herein provided. Said committee shall serve without compensation and shall advise and assist the department of labor and the workmen's compensation commission in the administration and operation of the workmen's compensation program as provided in this chapter. In the month of February, 1955 and in the month of February in each year thereafter, the governor shall appoint as many members of said committee as shall be necessary to succeed the persons whose terms are then expiring, to hold office until the first day of March in the 3rd year after their appointment and until their respective successors shall be appointed and qualified.

When this act shall take effect the governor shall thereupon appoint 3 members of said committee to serve until the 1st day of March, 1955, 2 members to serve until the 1st day of March, 1956, and 2 members to serve until the 1st day of March, 1957, and until their respective successors are appointed and qualified. Any vacancy which may occur in said committee shall be filled by the governor for the remainder of the unexpired term.

To this end every case of total disability or severe permanent partial disability on which compensa-

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ANNUAL REGISTRATION OF PHYSICIANS

Legislation enacted by the General Assembly, January Session, 1954

SECTION 1. Chapter 275 of the general laws, entitled "Licensing and regulation of physicians, surgeons, osteopaths and chiropractors," as amended by chapter 889 of the public laws, 1940, and by chapter 1638 of the public laws, 1945, is hereby further amended by adding thereto the following section:

"SEC. 30. On or before the first day of October in each year the administrator of professional regulation shall mail an application for annual registration to every person to whom a license to practice medicine or osteopathy in this state has been granted by the duly constituted licensing authority in the state. Every person so licensed who intends to register his or her license shall file with the administrator of professional regulation such application duly executed together with a registration fee of $1.00 on or before the first day of November in each year. Upon receipt of such application and fee the accuracy of the application shall be verified and the administrator of professional regulation shall issue a registration certificate effective November 2 and expiring the following November 1, and such registration certificate shall render the holder thereof a registered practitioner of medicine or osteopathy for that registration period.

"Any licensee who fails to register on or before November 1st in each year as provided above may be reinstated by the administrator of professional regulation on payment of the current registration fee of $1.00, plus an additional fee of $2.00.

"Any person who violates this section by failing to register each year as provided above shall be subject to a fine of $25.00. Failure to register under this section shall constitute a violation of Sec. 8 of this Chapter.

"A physician licensed to practice medicine or a physician licensed to practice osteopathy who does not intend to engage in the practice of his or her profession during any year, upon written request to the administrator of professional regulation may have his or her name transferred to an inactive list, and shall not be required to register annually or pay any registration fee as long as he or she remains inactive. Should he or she wish to resume the practice of medicine or osteopathy in this state, he or she will so notify the administrator of professional regulation and remit the current registration fee of $1.00."

SEC. 2. This act shall take effect upon its passage and all acts and parts of acts inconsistent herewith are hereby repealed.

REVISED WORKMEN'S COMPENSATION LAW

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tion has been paid for a period of one year shall be re-examined by the director of labor and such action shall be taken as in the judgment of said director and the commission, with the advice of the medical advisory committee, shall seem practicable and likely to speed the recovery and rehabilitation. A like study shall be repeated at intervals of not more than one year, as long as the injured employee continues to receive compensation. A copy of the re-examination report shall be sent to the employee, the employer and the attending physician of the employee.

Every physician treating any employee pursuant to this chapter shall, when the injury for which the employee is being treated involves an injury to his back which causes the loss of time for more than 7 days, file with the director of labor within 14 days after the first examination of the employee by the physician, a special report concerning such back injury. The director of labor, with the advice of the medical advisory committee, shall have the authority to prescribe the form of such special report, and may recommend specific tests to be performed in the diagnosis and treatment of such back injury, with the recommendation and approval of the employee's physician.

ANNUAL REPORTS

THE RHODE ISLAND MEDICAL SOCIETY

REPORT OF THE TREASURER

At the start of 1953 the Society had a cash reserve of $4,252.40. At the start of 1954 the cash reserve had been reduced to $2,240.83. This reduced reserve is due to the extraordinary expense of $2,800.00 for new oil heating equipment. Without this there would have been a profit for the year of about $788.43 in addition to the above mentioned reserve of $4,252.40 from previous years.

It is now apparent, however, that with inflation, increase in living and maintenance costs, the expense of running the Society is increasing and the amount of yearly income in excess of expenses is getting smaller each year. Repairs to the Medical Building, long delayed, must be undertaken in the near future. It is also apparent that every effort has been made and is being made to hold the line and to stay within the budget.

Therefore, it is recommended that careful consideration be given to plans for increasing the yearly dues in proportion to the obvious increase in the expenses of the Society. This should start in 1955. The present dues are $40.00 yearly. An increase of $5.00 yearly would increase the income about $3,000.00. With your permission, a study will be done to determine the yearly increase in new members and decrease in retired non-paying members so that the exact status can be stated at another Council meeting soon.

It is next recommended that the Agency Account with the Industrial National Bank be divided into two parts—A and B. Part A to consist of general funds not established for specific use and amounting to about $11,675.78, and Part B to consist of specific funds already established for specific use—such as the Harris Fund, the Day Fund.

It is further recommended that the income from Fund A or general fund be continually reinvested in such securities as the Bank and Council choose and not used for general expenses as it has been up to now. By this plan the Society will have a permanent, conservative investment account which should put extra funds to good use and provide for future needs as necessary.

Respectfully submitted,

JOHN A. DILLON, M.D., *Treasurer*

THE RHODE ISLAND MEDICAL SOCIETY

Financial Report, 1953

SUMMARY REPORT

Cash balance, General Account, January 1, 1953	$ 4,252.40
Receipts, 1953 (Exhibit A)	39,238.40
Total	$43,490.80
Expenses, 1953 (Exhibit B)	41,249.97
Cash Balance, General Account, January 1, 1954	$ 2,240.83

* * *

Cash on hand, General Account, January 1, 1954	$ 2,240.83
Cash in general account credited to special accounts (Exhibit C)	593.75
Cash on hand for Operating Expenses January 1, 1954	$ 1,647.08

* * *

Summary: General Account

Cash on hand, General Account, January 1, 1954	$ 2,240.83
Invested Funds, General Account, (Exhibit C) (Estimated)	11,675.78
Total assets, January 1, 1954	$13,916.61

EXHIBIT A — RECEIPTS — 1953

American Medical Association (for collection of dues)	$ 148.94
Annual meeting, dinner payments	1,800.00
Council meetings, dinner receipts	129.00
Dividends from invested funds (Agency Account)	1,049.65
Dues from members	27,057.50
Exhibits, balance due for 1953 meeting	772.50
Exhibits, advance for 1954 meeting	2,250.00
Interim meeting, dinner receipts	1,860.25
Medical Bureau (Use of building)	600.00
Miscellaneous	640.00
Providence Medical Association	2,930.56
Total	$39,238.40

EXHIBIT B — PAYMENTS — 1953

A.M.A. Dues Collection	$ 63.00
Annual Meeting, including dinner payments	3,857.67

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ON THE LIBRARY BOOKSHELVES

LIVING WITH A DISABILITY by Howard A. Rusk, M.D., Director, The Institute of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center, and Eugene J. Taylor; The Blakiston Company, Inc., Garden City, $3.50

The basis of this book is to make available existing inventions and discoveries which will help the disabled derive greater independence and happiness. To this end, Dr. Rusk has presented in his 278-page book a splendid picture of the outstanding progress of the relatively new field of medicine-rehabilitation of the disabled.

There are 250 excellent illustrations depicting the resourceful and, in some instances, ingenious appliances and procedures employed in promoting independence to the previously doomed invalid. Etiology is not emphasized. In nine chapters, the author has described the major problems from the practical approach. He deals with the patient rehabilitating himself for his personal habits and gainful employment, etc., as well as hobbies, such as, fishing, woodworking, etc.

This text should be made available to every patient with a disability, as it will prove most inspiring and encouraging. Furthermore, it should prove a major stimulus to the medical profession in expediting the establishment of a rehabilitation center for the State of Rhode Island, which, in this reviewer's opinion, is long overdue.

HENRY B. FLETCHER, M.D.

THE HEPATIC CIRCULATION AND PORTAL HYPERTENSION by Charles G. Child, III, M.D., W. B. Saunders Company, Phil., 1954. $12.00

Although, to most physicians, the title may suggest that this book would be a hard won tool for only the dedicated scientists, we are happy to say that this is far from being so. The liver has always been a subject of obscuritanism. Here is a large organ, interposed between the digestion and the circulation, with multitudinous functions, some partially glimpsed, others only a scent—or less. This led Bichat to postulate that nature would not have made the organ so large were its only function that of producing a secretion less abundant than the urine. Even, regarding the circulation of the liver, it has been stated that the story of circulation is buried under its own literature. Because the tools to assay the liver have been hard to come by, philosophic men chanced theories about the liver from the murky vapors of their bilious dreams. Thus, Galen vouchsafed the inspiration that the liver was the primary organ of circulation, and this was accepted until Harvey demonstrated the circulation of the blood in 1628. Then, indeed, was the medical night turned toward the day! But, as Professor Child stoutly testifies, "It was not, of course, the liver which was dead but Galen."

The author stated that his major objective was to help close the gap in time which always seems to exist between discoveries of the basic sciences and their clinical application to disease. But, he has done more than this for the student, the practitioner and the researcher—he has done it clearly, concisely, penetratingly and with a seemingly effortless and sprightly style. There is much meat here for all. For the student and the resident—here is what is known about the liver (up to the latest survival experiment on tying off the hepatic artery after preparation with antibiotics). For the researcher—here are the roads that have been traveled; and there is the marker to the future. For the surgeon—here is diagrammed the circulation and its variables to and from the liver; here is the story of the ancient and modern Eck fistulae; here are mental projections toward the operations of the future. For the internist—here is what is known about the liver and water balance; about diagnosis and treatment; about medical criteria for judging operability of patients with portal hypertension. And, for everybody, at the back of the book are the author's own fascinating experiments on the Macaca monkey. And, before the index, are short résumés of the case histories related or charted elsewhere in the book. These résumés are doubly valuable because they run the gamut of what might happen in and about the liver in a medical lifetime.

If the reviewer has seemed too exuberant in his superlatives, it is only because he is humbled in

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ANNUAL REPORTS

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Blue Cross—Physicians Service (Employee deductions)	231.90
Committees:	
Cancer	229.28
Diabetes	451.43
Grievance	22.50
Health Insurance	196.00
Industrial Health	341.06
Medical-Legal	108.00
Public Relations	271.50
Council meetings, dinner payments	207.30
Delegates to A.M.A. meetings	977.38
Donations and dues to organizations	133.00
Electricity	243.69
Fuel	669.47
Gas	69.59
General Expenses (Miscellaneous)	581.56
Insurance	1,299.00
Interim Meeting, including dinner payments	2,109.51
Journals and books	1,123.41
Legal	250.00
Library	687.49
Office supplies and equipment	1,438.25
Postage and printing	1,125.72
Refunds	400.00
Repairs, Library building	3,225.51
Salaries and taxes, including employee withholding and social security	20,708.27
Telephone	228.48
Total	$41,249.97

EXHIBIT C — AGENCY ACCOUNT

Agent: Industrial National Bank
Providence, Rhode Island

RECEIPTS:		
Net income collected, 1953		$ 1,049.65

* * *

INVESTED FUNDS

General Account

(Income, 1953: $347.15)

Par Value	*Investment*	*Book Value*
$2,000.00	U. S. Savings Bonds, Ser. "G", due 5/1/57	$ 1,904.00
$5,000.00	U. S. Savings Bonds, Ser. "G", due 12/1/60	4,845.00

* * *

50 shares	George W. Helme Company, $1.75 Pfd.	1,863.91
10 shares	Rochester Gas & Electric Corp. 4% Cum. Pfd.	948.27
10 shares	National Dairy Products Corp. Common	545.56
10 shares	American Telephone & Telegraph Corp. Cap.	1,539.43
	Sub-total	$11,646.17
	Principal cash balance in Agency Account	29.61
	Total	$11,675.78

E. M. HARRIS FUND

Established in 1921 by a donation of $5,000 by Dr. E. M. Harris for "upkeep of the Library building."

(Income, 1953: $252.50)

		Book Value
25 shares	Consolidated Edison Company of N. Y., Inc., $5.00 cum. Pfd.	$ 2,690.63
30 shares	Standard Oil Company (New Jersey)	2,465.70
	Total	$ 5,156.33

FRANK L. DAY FUND

Established in 1927 by a donation from the estate of Dr. Frank L. Day, to be utilized for the purchase of books.

		Book Value
10 shares	American Telephone & Telegraph Co. Cap.	$ 1,539.42
40 shares	National Dairy Products Corp. Common	2,182.25
		$ 3,721.67

Cash balance, special checking account, Industrial Nat. Bk., January 1, 1953	$ 638.96
Dividends from investments, 1953	210.00
Cash assets	$ 848.96
Expenses, books and periodicals, 1953	284.40
Cash balance, special checking account, Industrial National Bank, January 1, 1954	$ 564.56

JAMES H. DAVENPORT FUND

Established in 1930 by a donation of $1,000 for the purchase of books for the Davenport Collection of non-scientific books written by physicians.

		Book Value
10 shares	Rochester Gas & Electric Corp. 4% cum. Pfd.	$ 948.27
24½ shares	American Home Products Co. Common	803.12
	Total	$ 1,751.39
	Cash in General Account, January 1, 1953	$ 104.15
	Income, 1953	89.00
	Total	$ 193.15
	Books purchased, 1953	52.36
	Cash balance in general fund, 1/1/1954	$ 140.79

CHARLES F. GORMLY FUND

Established by the Society in 1945 with the cash balance accruing from surplus contributions from members of the Society for the purchase of an oil painting of Dr. Gormly presented to the Library. The fund is established for the purchase of medico-legal books.

Cash balance in the General Fund, 1/1/53	$ 38.44

* * *

Cash balance in the General Account, 1/1/54	$ 38.44

J. W. C. ELY FUND

A memorial fund established in 1912 by the son and the granddaughter of Dr. J. W. C. Ely, in the amount of $1,500, to be called the J. W. C. Ely Fund and the income from which was to be used for periodicals.

Cash balance in general account, January 1, 1953	$ 454.72
18 shares, American Home Products Company, Common Value: $586.92 Income, 1953	36.00
Total	$ 490.72
Books purchased, 1953	76.20
Cash balance in general account, January 1, 1954	$ 414.52

ENDOWMENT FUND

Started in 1912 when the Trustees of the Fiske Fund voted to take the remuneration allowed them by the will and present it to the R. I. Medical Society as the foundation of a maintenance fund for the support of the Library building.

20 shares, American Home Products, Common Value: $642.50 Income, 1953	$ 40.00

JAMES R. MORGAN FUND

Established by a donation in 1929 to be used for current expenses.

11½ shares, American Home Products Company, common Value: $374.79 Income, 1953	$ 23.00

HERBERT TERRY FUND

Established in 1928 by a donation from C. B. and C. H. Kenyon in memory of Dr. Herbert Terry, for the purchase of books and periodicals and for the binding of same for the Library.

26 shares, American Home Products Company, common Value: $856.66 Income, 1953	$ 52.00
Books and periodicals purchased, 1953	53.50

(Deficit of $1.50 paid from General Funds.)

AIR POLLUTION

The Air Pollution committee has held no meetings in the past year. As previously recommended, the Committee would like to urge physicians to report smoke violations to the local authorities. The Committee also urges that where no local authorities exist the district society take action to have such authority created.

FRANCIS H. CHAFEE, M.D., *Chairman*

CHILD HEALTH RELATIONS

The major work of the committee during the past year has been a consideration and appraisal of school health programs in Rhode Island.

The general organization of school physicians in Rhode Island was reviewed, and the following are the recommendations of the committee:

1. Frequency of school health examinations be standardized in Rhode Island.

2. Minimum salary of $500 yearly plus one dollar for each child seen per year.

3. The maximum number of pupils seen not to exceed 800 per year.

4. All school children in the state should be examined, public or private.

5. The type of examination of children should be determined in accordance with the procedure for schools with adequate health personnel as set forth in the publication, HEALTH APPRAISAL OF SCHOOL CHILDREN by Dean F. Smiley, M.D., and Fred V. Hein, Ph.D., as published and distributed by the American Medical Association.

School health programs were discussed by the committee, and the American Medical Association report, "Health Appraisal of School Children," was made available to members of the committee and copies were sent to the school physicians of the state.

Plans were pursued for the formation of a society of school physicians. On May 5, 1954, in conjunction with the annual meeting of the Rhode Island Medical Society, a luncheon meeting of the committee and the school physicians of Rhode Island will be held for the formation of an association of school physicians. It is hoped that regular meetings of this group will be held during the year and in this manner matters of policy of concern to this group will be pursued.

At our luncheon meeting on May 5, 1954, Dr. Donald A. Dukelow of the staff of the Bureau of Health Education of the American Medical Association, accepted our invitation to address the group.

It has also been suggested that a meeting of the committee and the school physicians be held at the time of the annual meeting of the Rhode Island Medical Society each year, and a guest speaker, well versed in problems of school health, be invited to address the session.

WILLIAM P. SHIELDS, M.D., *Chairman*

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DISASTER COMMITTEE

The chairman has met with Civil Defense many times during the year and attended the 4th National Target Areas Medical Civil Defense Conference held in Cincinnati, Ohio on November 14-15. Your Committee has met together several times and reassigned doctors to staff the emergency hospitals and the eight assembly areas.

There are eight dispersal centers at present. These are really collecting pools from which doctors can be sent out to where they are needed. In the event they cannot reach their assigned station, the doctors will report to one of these dispersal centers.

1. Fire Station at Humbolt and Cole Avenues
2. Fire Station at Rochambeau Ave. and Stanley St.
3. Fire Station at Admiral Street near Dante St.
4. Fire Station at Eaton Street and Academy Ave.
5. Fire Station at Dover Street and Mt. Pleasant Avenue.
6. Fire Station at Hartford Ave. and Melissa St.
7. Broad Street School
8. Control Center at Reservoir Avenue and Roger Williams Avenue

Emergency Hospitals are to be set up at Mt. Pleasant Avenue School, Oliver Hazard Perry School on Hartford Avenue, Gilbert Stuart Junior High, Roger Williams Junior High, Esek Hopkins High School, Hope High School.

Your chairman has not called a committee meeting lately because of the great confusion that exists since the hydrogen bomb explosion. A complete revamping of the Civil Defense Organization is being planned. As you have been reading in the papers, the new plan is evacuation of as many people from Providence and vicinity as quickly as possible. Whether this plan will be accepted is some question. We believe we should continue our organization as disaster groups and later, if they establish hospitals outside the city, we will be able to send teams to man these emergency hospitals.

Some progress has been made, however, in that better coordination between the Red Cross and the disaster groups has been accomplished. The dentists have volunteered to work along with us, and the nursing organizations have set up an organization to supply nurses to these various emergency groups and teams. There is much work to be done but, until the confusion is over, I do not believe that we can accomplish very much.

J. MERRILL GIBSON, M.D., *Chairman*

HEALTH INSURANCE

Your committee has continued to supervise the operation of the "Rhode Island Plan" which has operated without incident during the past year.

We have one new application for permission to sell insurance under this plan. The contracts are being reviewed by the attorney for the society. The decision on acceptance has not yet been made.

The committee formally considered the problem of "duplicate" coverage and "excess" coverage and, as a result of its studies, issued a report to the House of Delegates at an Interim Session. Following this report the House authorized the publication of "Instructions to Patients" for the processing of medical-surgical claim forms. The House also approved the issuance of a gummed sticker allowing the patient to authorize payment to the doctor in cases where the claim form did not specifically provide for such authorization.

Your committee then sent copies of these "Instruction Sheets" and "Authorization to Pay" forms to all the industries and businesses in Rhode Island carrying Commercial Medical-Surgical insurance. Following this, your Chairman communicated with several insurance companies and industries in adjudicating misunderstandings on the operation of the plan.

Your chairman reviewed the situation regarding excess and double coverage before a Staff Meeting at a Providence Hospital and the report was carried in the March, 1954 issue of the RHODE ISLAND MEDICAL JOURNAL. We have already had requests for reprints from distant societies.

We continue our contact with the Bureau of Accident and Health Underwriters in New York on the subject of medical and surgical care insurance, and we report progress at this time in our effort to have a uniform type of reporting form available for Medical-Surgical care reports.

The enrollment report of the companies participating in the Rhode Island Plan as of December 31, 1953, is as follows:

Company	*Total*	*Group*		*Individual*	
		Employee	Dependents	Owner	Dependents
Aetna Life Ins. Co.	2,122	1,172	950	0	0
*American Mutual Liability Ins.	0	0	0	0	0
Connecticut General Life Ins.	2,145	822	1,323	0	0
Continental Casualty Company	0	0	0	0	0
Equitable Life Assurance Soc.	5,077	1,806	3,271	0	0
John Hancock Mutual Life Ins.	0	0	0	0	0
Liberty Mutual Life Ins.	0	0	0	0	0
Metropolitan Life Ins. Co.	21,176	8,366	12,810	0	0
Monarch Life Ins. Co.	0	0	0	0	0
The Travelers Ins. Co.	2,246	861	1,385	0	0
Washington Nat'l. Ins. Co.	71	50	21	0	0
TOTAL	32,837	13,077	19,760	0	0

*American Mutual Liability Insurance Co. same as American Policyholders Insurance Co.

CHARLES L. FARRELL, M.D., *Chairman*

HIGHWAY SAFETY

The Highway Safety Committee of the Rhode Island Medical Society has met on some four occasions within the past six months. The meetings have all been devoted to discussion and consideration of a proposed bill changing the motor vehicle law in such a way as to more clearly eliminate those individuals who are medically unable to drive or if they do drive are actually or potentially dangerous to themselves or to others. The legislation originally proposed by Representative John Wrenn was discussed in considerable detail with Mr. Wrenn as well as a representative from the Department of Motor Vehicles. The original proposal which was intended to restrict all epileptics as well as those individuals suffering from periods of unconsciousness regardless of cause was considered too broad. It should be stated perhaps that the original proposal, if interpreted broadly, would include those individuals who might potentially develop a period of unconsciousness.

Discussions with Mr. Wrenn were stimulating and his cooperation in rewording his bill was most appreciated by the committee. The committee with Mr. Wrenn reviewed the licensing of all individuals as well as the limitation to the obtaining of a license by individuals in New England and other states.

A final draft of the bill was approved by the Committee prior to its introduction in the General Assembly by Mr. Wrenn. This final form was designed to protect citizens from unnecessary accidents caused by individuals who drive and who suffer from illnesses which are uncontrolled medically. At the same time the bill would work no hardship upon any individual who suffers from an illness but who is considered to be no risk on the road.

The legislation was passed by the House of Representatives, but it was not reported out by the committee in the Senate.

THOMAS L. GREASON, M.D., *Chairman*

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INDUSTRIAL HEALTH

During the past year the committee on industrial health has engaged in little activity other than consideration of the problems incident to the amendment of the state workmen's compensation law. The committee carefully reviewed all the legislation proposed, and made recommendations regarding the medical phases of the act.

The committee also gave consideration during the year to a proposal to circularize the membership of the Society to secure a listing of those physicians engaged in industrial work or interested in such service.

The committee looks forward to a restudy of the present standing orders for industrial nurses in order that an up-to-date guide based on local practices may be available to this group in Rhode Island.

The chairman of the committee represented the Society officially at the annual Congress on Industrial Health sponsored by the American Medical Association, and his report on that meeting was subsequently published in the RHODE ISLAND MEDICAL JOURNAL.

During the year an orginal and detailed report on pesticides was also prepared by the chairman of the committee at the request of the Council. This report was published in the Society's journal.

STANLEY SPRAGUE, M.D., *Chairman*

LIBRARY

During the past year the Library was visited by 1124 physicians and 846 other readers. This represented 78 fewer readers than the previous year, the slight drop apparently being on the basis of the omission of evening hours. 1315 journals and 307 books were circulated during the past year. The interlibrary loan arrangement was active, with this library being primarily on the loaning rather than the borrowing end, representing the importance of our library to the community. Photostatic copies of journal articles from the Armed Forces Medical Library were made, this being a less expensive procedure than borrowing journals from out-of-state libraries. Our Librarians prepared 210 bibliographies.

331 periodicals and serials and 420 bound volumes were received. Of those purchased, 32 were from the Day Fund, 6 from the Davenport Fund, 2 from the general account, 2 from the Veterinary Fund and 1 from the Gormly Fund. The Veterinary Fund represents an innovation and comprises funds made available by the Rhode Island Veterinary Medical Association. Human and animal medicine are so intertwined these days both in the field of research, and of diseases in common that this donation adds a valuable and novel contribution to our catalogue. In addition, individual veterinarians have made separate gifts. 35 volumes were received through the RHODE ISLAND MEDICAL JOURNAL, 4 from the medical library association exchange, 476 gifts from individuals of which 262 were duplicates, and many unbound journals and pamphlets. As of this date the approximate number of bound volumes in the Library is 40,184.

The response to the editorial in the RHODE ISLAND MEDICAL JOURNAL of December 1953 regarding "Friends of the Library" has been gratifying. Special labels imprinted "Friends of the Library of the Rhode Island Medical Society, gift of....." are pasted upon each gift issue.

During the past year, we have received certain special gifts:

> Fielding Ould—"A Treatise of Midwifery" in three parts, London, 1748. J. H. Aveling —"The Chamberlens and the Midwifery Forceps" London, 1882, both the gift of Dr. H. G. Partridge.
>
> G. B. A. Duchenne—"Physiology of Motion," Philadelphia, 1949, special edition copy #437, a gift of Dr. Arthur E. Martin.

From Mrs. Joseph Warren Greene, Jr. we have received the manuscripts and diplomas of Dr. Robert F. Noyes. Dr. Meyer Saklad presented us with a gift of an autographed copy of his book "Inhalation Therapy and Resuscitation." From Brown University we received a contribution to a "Union Catalog of Sixteenth Century Imprints of certain New England Libraries." It is of interest that our Library with its outstanding rare book and periodical collection is represented by several titles.

The list of donors during the past year is as follows: Doctors Adelman, Beardsley, Beck, Cameron, Chase, Corrigan, Gibson, C. L. Farrell, Hammond, Kramer, Jones, Lenzner, Martin, Partridge, Perry, E. M. Porter, Ronchese, M. Saklad, C. M. Silver, Simon and Thewlis; Prof. Beyer, Mrs. Benjamin C. Clough, Mr. Farrell, Mrs. Charles F. Gormly, Mrs. Joseph W. Greene, Jr., Mr. Wallace Maxon, Dr. Louis Pomiansky, Drs. Ralph and Morris Povar and Mrs. R. S. Rowland; the American Association of Genito-urinary Surgeons, American Cancer Society, American College of Cardiology, American College of Radiology, American College of Surgeons, American Medical Association, American Proctologic Society, Association of American Physicians, Brown University Library, Carrier Corporation, Charles V. Chapin Hospital, Chicago Medical Society, Ciba Pharmaceutical Products, Inc., Eli Lilly & Co., Health Information Foundation, John and Mary R. Markle Foundation, Library of the Wilmer Ophthalmological Institute of Johns Hopkins University, Linde Air Products Co., Miriam Hos-

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pital, MODERN MEDICINE, Muscular Dystrophy Associations of America, Inc., Mutual Insurance Co., National Foundation for Infantile Paralysis, National Nephrosis Foundation, Inc., New York University-Bellevue Medical Center, Peters House Library, Providence Health Department, Research Council for Economic Security, Rhode Island Cancer Society, Rhode Island State Dental Society, Rhode Island Heart Association, Inc., Rhode Island State Library Extension Service, Rhode Island Veterinary Medical Society, Rockefeller Foundation, Rockefeller Institute for Medical Research, State of New York, U. S. Government, and the Western Section American Urological Association; and loans from the Rhode Island Dermatological Society.

The Davenport Collection, comprising books of a non-technical nature, by and about physicians is being increasingly used since the borrowing privilege was instituted. Fellows are urged to avail themselves of the biographies, novels and poetry contained in this unique collection.

The Providence Medical Librarians are planning a second edition of the "Union List of Medical Journals" in Providence Medical libraries. The 2nd edition is expected to be ready this summer and it will indicate to each medical librarian in this community where journals may be locally obtained for interlibrary loan.

The committee wishes to express its appreciation of the fine service rendered by our able and cooperative librarians Mrs. Helen M. DeJong and Miss Grace Dickerman.

FOR THE COMMITTEE
IRVING A. BECK, M.D., *Chairman*
Henry H. Babcock, M.D.
Philip Batchelder, M.D.
Palmino DiPippo, M.D.
John F. W. Gilman, M.D.
Henry J. Hanley, M.D.
Herbert G. Partridge, M.D.
Francesco Ronchese, M.D.
Florence M. Ross, M.D.

MEDICAL DEFENSE AND GRIEVANCE

This Committee has held a few necessary meetings through the year. A few malpractice cases were discussed and appropriate action taken. Grievances cases have increased in number and are usually due to a misunderstanding on the part of the patient or are related to a financial problem. These cases are often simple of solution and require some investigation and a tactful reply to the aggrieved persons. In many instances, these complaints could be avoided if the physician would explain in detail to the patient the circumstances involved and also discuss the financial problem so that both parties are satisfied.

Fellows are urged to report promptly any case where a patient, by his attitude, seems likely to resort to legal measures for adjustment of a dispute or dissatisfaction with treatment even if the case has not been referred to a lawyer. In view of the rising cost of malpractice insurance, every physician should review his coverage, and, if in doubt, the amount of protection should be substantially increased.

ROLAND HAMMOND, M.D., *Chairman*

MEDICAL-LEGAL

The committee had no matters referred directly to it during the year, and as a result held no meetings. However, the committee cooperated with the Providence Medical Association in its meeting on legal medicine, held on March 1, 1954, at which the members of the Rhode Island Bar Association were invited guests. The speaker was Dr. Richard Ford, head of the department of legal medicine at Harvard Medical School. In the opinion of the committee similar joint meetings with the legal profession should be held annually.

LAURENCE A. SENSEMAN, M.D., *Chairman*

MEDICAL-PHARMACEUTICAL

The Medical-Pharmaceutical Committee were guests of the Rhode Island Pharmaceutical Association at a dinner on December 6, 1953, at the Metacomet Golf Club. The reason for the meeting was to formulate a plan to hold a medical-pharmaceutical forum. This was held at the Medical Library on December 9, 1953, at 8:30 p.m. It was open to all members of the Medical Society and Pharmaceutical Society.

The forum was a round-table discussion. The panel members for the doctors were Dr. John Streker, Dr. Herbert Hager; for the pharmacists they were Dr. Arthur Console, Mr. William Pinault, Mr. Leo C. Clark and Mr. Charles P. Gleason. Several questions, answers and solutions pertaining to the druggists and medical profession were discussed that evening. The purpose was to bring a better relationship and understanding between the doctors and druggists.

FRANK I. MATTEO, M.D., *Chairman*

REPORT OF THE COMMITTEE ON MENTAL HEALTH

The Committee on Mental Health presents the following recommendations to the House of Delegates:

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1. That the Medical Society commend the PROVIDENCE JOURNAL BULLETIN for their interest in the field of mental health in this state.

2. That there should be more papers presented on the subject of mental health at the regular meetings of the Rhode Island Medical Society. Guest speakers, who are prominent in the field of psychiatry, from teaching centers such as Boston, Massachusetts, might contribute, as well as members of the Rhode Island Medical Society itself.

3. That the Medical Society, through the committee on Mental Health, establish professional liaison with the Rhode Island Branch of the American Psychological Association.

4. That the Medical Society, in conjunction with its Legal Counsel, and the Committee on Mental Health, review the Medical Practice Act of the State of Rhode Island, with the possibility of including in that Act, "the diagnosis and treatment of mental diseases and disorders," within the definition of the practice of medicine.

This is in line with a recent recommendation of the Executive Committee of the American Psychiatric Association, and is designed to prevent improperly trained individuals from treating mental and nervous diseases and disorders. The committee does not feel that any particular problem exists in this state where there has been to date excellent cooperation between psychologists and psychiatric social workers, and psychiatrists. However, in other states, a very serious problem already exists, and there is a great deal of confusion as to who should treat mental and emotional disorders. While we still have a good working relationship with other specialists in the field of mental health, and before any severe problem arises, we feel that defining who shall treat, and who shall take the responsibility for the mentally ill individual should be done now.

Four basic points underlie this position:

First, the diagnosis and treatment of a sick patient entails responsibility. That is, physicians are licensed to practice, and are therefore legally qualified to diagnose and prescribe treatments for sick people.

Second, physicians, and only physicians, are trained adequately to discharge this responsibility.

Third, mental illnesses are well defined disease entities, and these are clearly described and delineated in the "Standard Nomenclature" and "Definition of Terms" officially recognized by the medical profession.

Fourth, it is a basic tenet of modern medicine that the psychological and physical components of an illness cannot be separated in diagnosis and treatment. At any point in a disease process psychological symptoms may give rise to, substitute for, or run concurrently with physical symptoms, or vice versa. Therefore, psychiatry is opposed to the independent isolated treatment of psychological symptoms by non-physicians.

We wish to emphasize, however, that we in no way wish to infringe upon the sympathetic counsel given by clergymen, teachers, nurses, etc, whose help we often need in the treatment of our patients.

Respectfully submitted,

WALTER E. CAMPBELL, M.D., *Chairman*

NUTRITION

The Nutrition Committee has not been formally active this year although the members have been ready and willing. As individuals, however, they have been well represented in the work of the Nutrition Council of Rhode Island, in Diabetic Week, and in cooperation with the state nutritionists.

WILLIAM L. LEET, M.D., *Chairman*

COMMITTEE ON PUBLIC LAWS

The Committee on Public Laws carefully reviewed all legislative acts placed before the General Assembly during its 1954 session, and expressed for the Society opinions relative to certain of the measures. The session was marked by the passage, after several years of controversy, of an amended workmen's compensation law which establishes a commission of three lawyers on long term tenure to act as a hearing board on all workmen's compensation cases.

The biggest disappointment was the failure of the Senate to bring out of committee the bill permitting towns to establish by joint venture district public health units. The legislation stemmed from a study by a special commission named by the Governor which presented a prompt and complete report to the Assembly advocating the creation of such public health services for the benefit of approximately 218,000 Rhode Islanders living outside the metropolitan areas where local health departments are fairly well organized now.

A brief résumé of the legislative session as regards health measures is presented as follows:

Legislation Enacted

Annual Registration of Physicians

All physicians desiring to register their license must do so by October 1. Fee is $1.00. Failure to register within the month following, establishes the fee at $2.00. Violation of the law calls for a $25.00 fine. Failure to register does not involve revocation of licensure. Legislation is aimed as aid to the State Health Department to compile an accurate register of physicians.

Workmen's Compensation

The workmen's compensation law was amended to establish a three-member commission having such jurisdiction as may be necessary to carry out the provisions of the act. The commission is one of record with the same rights of subpoena and also the same rights to cite and punish for contempt as exist in the superior court.

The medical care sections provide these changes from the present operation:

(1) The maximum allowance for services and medicines, exclusive of hospital services, is increased from $500 to $600 in the case of an employee hospitalized for more than 14 days.

(2) Any dispute regarding the reasonableness of the amount of any charge for services or medicine shall be determined by the commission after hearing, and its decision shall be final, if supported by a majority of the medical advisory committee (see page 387).

(3) The physician's written notice that he is treating a workmen's compensation beneficiary is to be filed within 15 days, instead of 7 as now required, but in addition the new law stipulates that every two months thereafter while the treatment continues a written progress report must be sent to the employer and a bill for services to date, and further, he must present his final bill for all unpaid services within three months after the conclusion of services.

(4) The impartial examiner no longer will have to send a copy of his report to the employee, as the employer or carrier must do that now upon receiving the medical report.

(5) The impartial examiner's report must be filed within 96 hours of the completion of each and every examination.

(6) The impartial examiner may be summoned for the purpose of cross examination by the commission.

(7) A medical advisory committee of seven physicians is to be appointed by the Governor to serve without compensation for staggered terms to assist the department of labor and the commission. Three physicians will serve until March, 1955, two until March, 1956, and two until March, 1957, and thereafter appointments annually to fill the vacancies.

(8) Every case of total disability or severe permanent partial disability on which compensation has been paid for a year will be reviewed and such action taken by the director of labor or the commission, with the advice of the medical advisory committee, as shall seem practicable and likely to speed recovery.

(9) With the advice of the medical advisory

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committee the director of labor has the authority to prescribe a special report for back injuries, and to recommend specific tests to be performed in the diagnosis and treatment of such back injury, with the recommendation and approval of the employee's physician.

Mental Health

A three million dollar bond issue referendum bill was passed which, if approved by the voters next fall, will provide for the construction of a third new structure to be a geriatrics building at Howard. Work is scheduled to start soon on two new buildings to be financed out of a three million dollar bond issue voted in 1952.

Also enacted was a bill providing for a $250,000 appropriation out of surplus to engage additional professional personnel at the State Hospital for Mental Diseases.

Narcotic Drugs

An act was passed making possession of barbiturates without a prescription illegal and increasing the penalties. The bill also broadens the definition of narcotic drugs to cover any drugs found by the director of health, after reasonable notice and opportunity for hearing, to have an addiction-forming or addiction-sustaining liability similar to morphine or cocaine.

Hospital Appropriations

Two hospital grant bills were enacted. One appropriates $104,800 for charitable purposes and included $31,500 for six hospitals, and the other re-imbursed voluntary general hospitals for the cost of maintaining facilities for patients who couldn't pay their bills, in the amount of $397,225. The distribution on the latter measure was as follows: Rhode Island Hospital, $202,300; Miriam Hospital, $96,300; Woonsocket Hospital, $44,925; Kent County Hospital, $23,300; Newport Hospital, $20,000; and Pawtucket Memorial Hospital, $10,400.

Practical Nurse Training

A resolution was passed in concurrence to create a nine-member committee to look into the feasibility of enlarging facilities in Rhode Island for the training of practical nurses. The committee will be appointed by the Governor and will include four members of the Assembly. It is to report at the 1955 session.

Milk Control

A measure reported to tighten milk standards of the state was enacted to provide that the allowable bacteria count of milk before pasteurization would be cut in half, and would in addition require standards on the coliform content of milk and provisions for testing the efficiency of pasteurization processes. The requirement for total solids content would be reduced from 12 per cent to 11.50 per cent.

Miscellaneous

A bill imposing penalties for violation of the anti-pollution orders of the division of sanitary engineering of the department of health was approved, while a bill detailing steps that the director of health shall take in determining the degree of pollution of waters overlying shellfish grounds, passed by the Assembly, was vetoed by the Governor.

Compulsory vaccination of dogs in areas quarantined by the state veterinarian was approved.

Farmers raising more than four hogs on garbage are now compelled under an act passed to cook garbage, and to pay a license fee of $1.00.

Health Bills left in Committee Files

Public Health Service

A detailed report by a special commission including several physicians named by the governor provided the impetus for legislation for three new health districts in the state to be created by cooperative action of the towns for the purpose of expanding and extending public health activities. Financing would be by diverting the state beverage tax due the 32 towns into the health program, plus town and matching state funds to make up the difference.

The bill passed the House but for reasons unknown publicly it failed to come out of the Senate Finance Committee for vote.

Reporting of Epilepsy

A bill supported by the Society that provided for the reporting by physicians of persons known to be suffering with epilepsy or with recurrent periods of unconsciousness uncontrolled by medical treatment, was passed by the House, but left in the files of the Senate Judiciary Committee.

New England Higher Education Compact

An act to ratify a compact for a New England Board of Higher Education was passed by the House and left in the Senate Judiciary Committee files. The Society questioned the approval of such legislation when the bill was introduced, on the grounds that before a compact was entered into some study of the need for, and utilization of professional personnel in the state should be attempted prior to the initiation of a scholarship program.

Medical School at the University of Rhode Island

A resolution that would create a special commission to study and report upon the feasibility of setting up a medical school at the University of Rhode Island did not move from the House Finance Committee.

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Basic Science Law Amendment

A bill that would substitute service in the medical corps (any grade) of the armed forces for the educational requirement of preprofessional education as a prerequisite for basic science examinations failed to move from committee.

Labor Representation of Blue Cross and Physicians Service

Companion bills requiring that two representatives of organized labor be named to the boards of directors of both Blue Cross and Physicians Service were returned to committee after being brought to the floor of the House for discussion. Subsequently similar legislation but including also a member of the House and a member of the Senate in addition to the labor delegates was brought to the floor of the House from the House Corporations Committee but it was not approved.

Name for State Sanatorium

An Assembly conflict arose over a proposal to name the Wallum Lake Sanatorium in honor of Dr. U. E. Zambarano. The bill passed the House, and was amended in the Senate to honor Drs. Harry Lee Barnes, Virgil H. Danford, and Zambarano by naming three houses at the sanatorium for them. The amended bill, passed by the Senate, ended up in the House Finance Committee files.

Blood, Chemical Tests for Alcoholic Autoists

A bill that would permit chemical test of an autoist's breath, blood, urine, or saliva for the purpose of determining the alcoholic content of his blood was left in the House files.

Free Medical Care for Mothers of Veterans

An act similar to the one passed a year ago but vetoed later, was re-introduced to provide payment of reasonable medical and hospital expenses for the mothers of United States deceased veterans of *any* war, declared or undeclared, in which the country has heretofore been or is now engaged, was not reported out of committee in the House where the measure was introduced.

Hospital Liability

For the second year a bill was left in committee in the House that would require every hospital sustained in whole or in part by charitable contributions to be liable for the neglect, carelessness, want of skill, or for the malicious act of *any* of its officers, agents or employees in the management of, or for the care or treatment of, any of the patients or inmates of such hospital.

JAMES H. FAGAN, M.D., *Chairman*

PUBLIC POLICY AND RELATIONS

The committee has been active throughout the year. It has prepared press and radio releases in connection with matters of public policy and relations involving the Society, and it has held conferences with the president. The publication of RIMSCOPE, an informative bulletin for the members of the Society, has been continued during the year under the auspices of the committee.

CLIFTON B. LEECH, M.D., *Chairman*

VETERANS AFFAIRS

The problem of providing veterans with medical care for non-service connected disabilities has provoked a great amount of discussion throughout the country during the past year.

The policy of the American Medical Association was clearly enunciated at the annual meeting in June, 1953, when the action of the House of Delegates formulated a resolution which stated briefly that the provisions of medical care and hospitalization benefits for veterans in Veterans Administration and other Federal hospitals should be benefited by new legislation limiting medical to the two following categories: (1) veterans with peacetime or wartime service whose disabilities or diseases are service incurred or aggravated, and (2) within the limits of existing facilities to veterans with wartime service suffering from tubercular or psychiatric or neurological disorders or of non-service origin, who are unable to defray the expenses of necessary hospitalization. (3) That medical care and hospitalization in veterans hospitals for the remaining groups of veterans with non-service connected disabilities be discontinued and the responsibility for the care of this group revert to the individual and the community where it rightfully belongs.

In accordance with the above, each state society was asked to establish a committee on veterans affairs. Subsequently, Dr. Earl F. Kelly appointed such a committee September 28, 1953.

A regional meeting was held in New York City on November 13, 1953, for informative purposes, and also to instruct the various state committees as to the best manner to present the salient facts of the A.M.A. policy to the states, local county societies and the general public.

A second similar meeting was held in Boston, Mass., on March 28, 1954.

Your committee has met in the interval and discussed the problem and also methods of presenting what data is available to the district societies.

The chairman has addressed the Pawtucket Medical Association on this subject at their regular meeting in February.

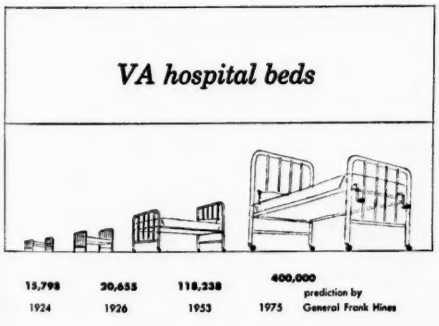
The report of the committee has been properly made both to the House of Delegates and also to the Council. These reports have been printed in the RHODE ISLAND MEDICAL JOURNAL. The recommendations of the committee have been made to both these bodies at the end of each report.

There is nothing more to add to the report or the recommendations.

It was the general feeling at the Regional meetings that the profession should be educated as regards veterans affairs and the A.M.A. policy; and contacts be made with the respective representatives and Senators in Washington to acquaint them with the medical profession's stand on the subject at hand.

ROBERT T. HENRY, M.D., *Chairman*

In Viewing the VA Medical Program . . .



Former VA Administrator Frank Hines estimated that by 1975 under existing VA medical legislation, approximately 400,000 hospital beds will be needed. Yet medical authorities are convinced the VA cannot attract sufficient medical personnel to staff more than 120,000 beds. The VA now maintains three times the number of beds needed for treatment of service-connected cases.

In Viewing the VA Medical Program . . .

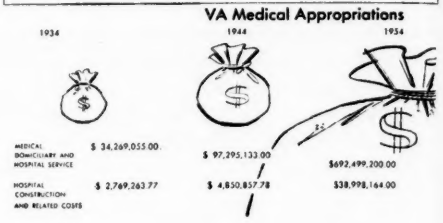
average length of stay in VA hospital

	Average (days)	World War II (days)	World War I & Other (days)
TB	205.8	203.6	210.2
NP	178.3	89.2	430.6
GMS	30.8	23.5	42.5

The average length of stay in VA hospitals for World War I veterans is considerably greater than for World War II veterans, which now comprise 76% of the total veteran population. The greatest pressure is yet to be exerted on VA hospitals as World War II veterans grow older and require increased medical care for disabilities unrelated to military service.

In Viewing the VA Medical Program . . .

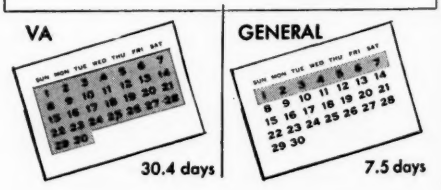
increasing tax burden



In twenty years, the cost of the VA medical program to U. S. taxpayers has increased 1,875%. Yet only 15% of the patients treated in VA hospitals are veterans with disabilities incurred while in uniform. The VA medical program is now second in size and expense only to the nation-wide system of socialized medicine in Great Britain.

In Viewing the VA Medical Program . . .

comparison of length of stay in VA and general hospitals
GM&S



General medical and surgical patients in VA hospitals are confined four times longer than in non-federal hospitals. VA hospitals admit patients for examination, diagnosis, and treatment, much of which is normally undertaken outside civilian hospitals. Also, VA patients often remain hospitalized throughout the entire medical treatment period, whereas non-VA patients are usually treated at home during their convalescence. This is a major factor in the tremendous cost of the VA medical program.

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contemplating the mountains of work that some men do in a lifetime. And when this work is a clear and burgeoning milestone, what can one say?

HARRY HECKER, M.D.

75 YEARS OF MEDICAL PROGRESS 1878-1953. A. H. Robins Company, Edited by Louis H. Bauer, M.D.

This interesting small book seems to be the culmination of the remarkable meeting of the World Medical Association which the A. H. Robins Company, Inc., of Richmond, Virginia, sponsored in April 1953, entertaining delegates from Central and South America and a seventy-five-year-old physician and wife from each state in the Union. In all its aspects this was a delightful meeting, with a series of excellent papers by distinguished men outlining the progress of the last seventy-five years in their specialties.

This finely gotten up book, edited by Dr. Louis H. Bauer, who was at the time of the meeting the president of the American Medical Association and the secretary general of the World Medical Association, contains those papers. They are all short and with little detail, but for that reason allow each man to show his cleverness in that most difficult art of presenting multum in parvo.

Rhode Island readers will be interested to see that the concluding chapter, on urology, was written by Dr. John H. Morrissey, who grew up and had his intern training in this state. It is pleasing to say that Dr. Morrissey has one of the most easily read, informative papers in the group.

On the other hand Dr. Simmons in his article on preventive medicine and public health, distinguishes our fair city by this quotation from our Superintendent of Health in 1882:

"I have known one case in this city where nearly all the inmates of a large house had typhoid fever from the decomposition of a large quantity of potatoes in the basement." Dr. Simmons, our Chapin Orator of a few years ago, must know that Dr. Charles V. Chapin, who took over the Superintendency in 1884, was probably the last man in the world to attribute typhoid fever to filth or the decomposition of animal or vegetable matter. Throughout his career, despite much pressure put upon him, he refused to interest himself in these disagreeable but not pertinent matters.

Physicians should find this an interesting book. The Robins Company is to be commended for the manner in which they demonstrated and enlightened the interest.

PETER PINEO CHASE, M.D.

THE NURSING MOTHER by Frank Howard Richardson, M.D., F.A.C.P., F.A.A.P. Prentice-Hall, Inc., New York, 1953. $2.95

continued on next page

This compact book is written to make known the important considerations in breast feeding to the women who wish to nurse their babies. Dr. Richardson, an avowed enthusiast of breast feeding, skillfully integrates his experience with the available evidence for this type of infant feeding. The first five chapters are devoted exclusively to why breast feeding is so desirable. The author follows through with a good account of all phases of the actual methods of breast feeding. Detailed advice is given on the prenatal care of the breasts right through to a full account of weaning. Illustrations elucidate many points. Anatomy of the breast and the physiology of human milk production are related in a manner understandable to the layman. A series of questions and answers anticipates many of the trepidations which may confront the expectant mother. Some of the points handled on infant feeding such as the use of soap suppositories are controversial. Dr. Richardson makes it clear to the reader that his opinion on these subjects is not universal.

The book is written for the average mother in simple, non-technical language. On the other hand, the book is instructive enough on a subject usually ignored during the physician's formal training to make it profitable reading for all. Having read this book we are inclined to agree with Dr. Richardson that "The Breast Fed Baby is the Best Fed Baby."

BETTY BURKHARDT MATHIEU, M.D.

AN ATLAS OF PELVIC OPERATIONS by Langdon Parsons, M.D., and Howard Ulfelder, M.D. W. B. Saunders Company, Phil., 1953. $18.00

This is a wonderfully useful book on the technique of pelvic surgery. It also illustrates many abdominal operations. It is a direct take-off on Cutler and Zollinger's ATLAS which has been well appreciated by many surgeons. The many meticulously drawn illustrations on 11 x 14 inch pages make the surgery seem very simple and easy. The one thing that is not present is the ever present blood, sweat and fat tissue that one encounters in attempting this surgery. It does not elaborate on the method of exposure which is necessary to see the fine details presented in the wonderfully drawn illustrations, but the text which accompanies these illustrations points out the exact moment in each operation where trouble is most likely to occur and explains the steps to be taken if the difficulty is encountered.

The operations for malignant pelvic disease come from a group that have been pioneers in this field, namely, Dr. Parsons, Professor of Gynecology at Boston University, Dr. Ulfelder, Assistant Professor of Gynecology at Harvard, who have both been associates of Joe Vincent Meigs of Boston. In fact, the book is dedicated to Dr. Meigs. This section is the first well-illustrated operative technique of the Wertheim hysterectomy.

This is a book that every surgeon, both general and gynecological, should have available and should consult from time to time because of the many technical tricks or maneuvers that one may find useful.

ROBERT W. RIEMER, M.D.

SEXUAL BEHAVIOR IN THE HUMAN FEMALE by Alfred C. Kinsey, Wardell B. Pomeroy, Clyde E. Martin, Paul H. Gebhard and others. W. B. Saunders Company, Phil., 1953. $8.00.

The much-heralded Kinsey report on SEXUAL BEHAVIOR IN THE HUMAN FEMALE is one of the most difficult books that I have ever had to read. It is far from the sensation that the average individual has been led to believe that it is.

In the first chapter the authors, in describing the scope of the study seem to be making a plea for some justification of their publication. Also, in this chapter, we are made to believe that better laws relative to sex matters may evolve as a result. This aim seems to have been lost along the way.

In describing the "sample" used the authors tell us that their sample is inadequate in its representation of the females in the U.S.A. Again, this statement is forgotten later in the book when we are informed that the numerous statistics gathered by voluntary information is truly representative.

The book is quite filled throughout with statistical tables based upon voluntary information from various groups approached with an "aid to science" approach. That an adult along in years can recall with accuracy incidents occurring at three years of age and that an infant is experiencing sex in the manner described by the authors is certainly questionable.

The volume further describes all types of sexual activities, along with which Dr. Kinsey proceeds to enter the field of psychiatry and neurology wherein he proves himself inadequate and contradicts many of his earlier statements in the book.

There is an undercurrent of suggestion that women in the higher educational fields are dangerous in youth direction and education because of their frustrations. This I believe to be highly unjustified.

Ventures into the field of endocrinology contribute nothing to our already existing knowledge.

Throughout the latter part of their book, the authors, in emphasizing only the physiological in sex in mammals, refer constantly to the human animal. It would seem that they forget that "the human female" is a woman possessed of psychological and spiritual qualifications which transcend the physiological, and that true happiness cannot exist where a moral code is missing.

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